STATE OF NEW JERSEY

STATE HEALTH BENEFITS PROGRAM

TRADITIONAL PLAN

MEMBER HANDBOOK

FOR EMPLOYEES AND RETIREES

Department of the Treasury
Division of Pensions and Benefits

Administered by
Horizon Blue Cross Blue Shield of New Jersey

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INTRODUCTION

This Handbook, your plan document, is designed for use by participants enrolled in the State Health Benefits Program (SHBP) Traditional Plan. Keep this handbook where you can access it when you have questions about your health **coverage**.

Terms in this handbook that are printed in **bold** text are explained in the Glossary (beginning on page 67).

State law and the New Jersey Administrative Code govern the SHBP. The State Health Benefits Commission is the executive organization responsible for overseeing the State Health Benefits Program. The Commission includes the State Treasurer, the Commissioner of the Department of Banking and Insurance, and the Commissioner of the Department of Personnel or their designated representatives. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, is responsible for the daily administrative activities of the SHBP.

The Traditional Plan is an **indemnity plan** that provides reimbursement of expenses for treatment of **illness** and **injury**. The Traditional Plan is self-insured. Funds for the payment of claims and services come from funds supplied by the State, participating **local employers**, and **members**.

The Traditional Plan is administered for the SHBP by Horizon Blue Cross and Blue Shield of New Jersey (Horizon BCBSNJ) which means that Horizon is the claims administrator for all eligible members. This plan allows you to use any eligible licensed provider, as defined by the plan, for covered medical services. The plan pays only for the diagnosis and treatment of illness or injury. It does not pay for preventive treatment such as immunizations, physical exams, screening tests, and well-care visits to **doctors**.

STATE HEALTH BENEFITS PROGRAM INFORMATION

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for **coverage** is determined by the State Health Benefits Program (SHBP). Enrollments, terminations, changes to contracts, etc. must be presented through your **employer** to the SHBP. If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

To be eligible for **State employee** coverage, you must work full-time or be an appointed or an elected officer of the State of New Jersey. For State employees, full-time normally requires 35 hours per week.

To be eligible for **local employer** coverage, you must be a full-time employee or an appointed or elected officer receiving a salary. Each employer defines the minimum hours required for full-time by a resolution filed with the SHBP, but it can be no less than an average of 20 hours per week. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year.

Eligible Dependents

Your **eligible dependents** are your spouse and/or your unmarried children under age 23 who live with you in a regular parent-child relationship. This includes children who are away at school as well as divorced children living at home and dependent upon you for support. If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases. Coverage for an enrolled child will end when the child marries, moves out of the household, or turns age 23. Coverage for children age 23 ends on December 31 of the year in which they turn age 23 (see the **COBRA** section on page 10 for continuation of coverage provisions).

If a child is not capable of self-support when (s)he reaches age 23 due to mental **illness**, mental retardation, or a physical disability, coverage under the SHBP may be continued. To request continued coverage, call or write the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 23, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Enrollment

You are not covered until you enroll in the SHBP. You must fill out a *NJ State Health Benefits*

Program Application and provide all the information requested. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so (see exceptions below). Open Enrollment periods generally occur once a year. Information concerning the duration of the Open Enrollment period and effective dates of coverage are announced by the Division of Pensions and Benefits.

Change of Coverage

To change your coverage you should contact your benefits administrator or human resource representative and complete a *NJ State Health Benefits Program Application*. You are eligible to change your coverage under the following circumstances.

- You marry and want to enroll your spouse and newly eligible dependent children. You must file a new *NJ State Health Benefits Program Application* within 60 days of the marriage.
- You need to enroll a new child. You must file a new *NJ State Health Benefits Program Application* within 60 days after birth or adoption and submit legal documentation.
- You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives with you, or turns 23).
- You are going on a **leave of absence** and cannot afford to pay for coverage. You can reduce your coverage, for example, from family to parent and child when you go on leave and increase it back to family upon your return to work.
- Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage. You have 60 days from the date of the event to make adjustments to your coverage that are necessary to compensate for the loss of this coverage. A copy of your spouse's and or dependent's Certificate of Continued Coverage must be submitted with the *NJ State Health Benefits Program Application*.
- Your child, under the age of 23, has divorced and moves back into your household, and is dependent upon you for support and maintenance. You must file a *NJ State Health Benefits Program Application* within 60 days after the child has returned home, with a copy of the child's divorce decree, if you wish to enroll this child under your coverage.

Effective Dates of Coverage

There is a waiting period of two months following your date of hire before your SHBP health benefits coverage begins, provided you submit a completed *NJ State Health Benefits Program Application*. Your enrolled eligible **dependent's coverage** is effective the same date as yours provided you have paid any required contribution.

Coverage for **State biweekly employees** begins on the first day of your fifth payroll period. The exact date of your coverage will be determined by the State's centralized payroll date schedule. Contact your benefits administrator or human resource representative if you need to know the exact date of coverage.

If you are a local government or local education employee or a **State monthly employee,** your coverage begins on the first day following two months of employment. For example, if you start work on September 15, your coverage will be effective November 15. The following *exceptions* apply to this effective date of coverage.

- If you have at least two months of service on the date your employer joins the SHBP, your coverage starts on the date your employer enters the program.
- If you have an annual contract, are paid on a 10-month basis, and begin work at the beginning of the contract year, your coverage will begin on September 1.
- If you were enrolled in the SHBP with your previous employer and your coverage is still in effect on the day you begin work with your current employer (**COBRA** coverage excluded), your coverage begins immediately so you have no break in coverage. (See Transfer of Employment, below.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, birth, adoption, etc.) providing the application is filed within 60 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the Health Benefits Bureau. Dependent children are automatically terminated as of the end of the year they attain age 23 and do not require the completion of an application to decrease coverage.

Transfer of Employment

If you transfer from one SHBP-eligible employer to another, including transfer within State employment, coverage may be continued without any **waiting period** provided that you:

- are still covered by the SHBP (**COBRA** coverage excluded) when you begin in your new position; or
- transfer from one participating employer to another; and
- file a new *NJ State Health Benefits Program Application* listing the former employer in the appropriate section of the application.

Leaves of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for **illness**.
- Approved leave of absence other than illness.
- **Family Leave** Act (federal and state).
- Furlough.
- Workers' Compensation.
- Suspension (**COBRA** continuation only).

When you take an approved leave of absence, you may reduce your coverage (for financial reasons) and increase it again when you return from leave. When you return to work, your benefits and those of your eligible family members are reinstated upon completion of a *NJ State Health Benefits Program Application.* Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence. When the leave of absence is due to suspension, you are not eligible for benefits, with the possible exception of **COBRA**.

Family and Medical Leave Act

State and **local employees** participating in the SHBP are entitled to have their coverage continued at the expense of their employer while they are on family leave. To qualify for the federal Family and Medical Leave Act of 1993 (FMLA), you must have a personal illness, a newborn child, or need to care for an ill family member, and be employed for 12 months. The FMLA defines the family member as a spouse, parent, or child. The FMLA provides up to 12 weeks in a 12-month period.

To qualify for the New Jersey Family Leave Act (NJFLA), you must have a need to care for an ill family member or a newborn child. There is no provision for an employee's own personal illness. The NJFLA provides up to 12 weeks in a 24-month period.

If an employee takes a leave for the care of a family member, both the FMLA and the NJFLA will run concurrently. If an employee takes a leave for maternity, they are on the FMLA. After their doctor releases them from their maternity leave, they can take the NJFLA for the care of the newborn child. This then provides the parent with up to 24 weeks of employer paid benefits.

Furlough

If you take an approved furlough, your SHBP coverage will continue at the employer's expense. You must remit to your employer, in advance, that portion of the premiums you normally pay, if any.

For State employees, voluntary furlough extensions beyond the normal 30 days allowed will be treated as an exceptional case. You will have to pay for the full cost of coverage for your extended furlough days in 10-day increments or drop your coverage for the entire **benefit period**(s) in which you take a furlough day.

End of Coverage

Coverage for you and your dependents will end if:

- — you voluntarily terminate coverage;
- — your employment terminates;
- — your hours are reduced so you no longer qualify for coverage;
- — you take a leave of absence and do not make required premium payments;
- — you enter the Armed Forces and are eligible for government-sponsored health services;
- — your employer ceases to participate in the SHBP; or
- — the SHBP is discontinued.

Coverage for your dependents will end if:

- — your coverage ceases for any of the reasons listed above;
- — you die;
- — your dependent is no longer eligible for coverage (divorce of a spouse; children marry, move out of the household, or turn age 23 unless the dependent child qualifies for continuance of coverage due to disability — see page 1);

— your payment for coverage is not made when due; or
— your enrolled dependent enters the Armed Forces.

Return from Leave of Absence

If your coverage has terminated while on an approved leave of absence, when you return from the leave, your benefits and those of your eligible family members are reinstated after you complete a *NJ State Health Benefits Program Application*. **You must complete this application within 60 days after you return to work.** Coverage becomes effective on the date you return to work if you are a State monthly or local employee or on the first day of the pay period in which you return to work if you are a State biweekly employee. You may enroll in any plan at any level of coverage for which you are eligible when you return from an approved leave of absence. This reinstatement provision applies to all approved leaves.

If you retained your coverage at a reduced level while on an approved leave of absence, you may return to your former level of coverage or any other eligible level of coverage upon your return to work.

If you retained your coverage at a reduced level while on a leave of absence and were not actively at work during an Open Enrollment period, you may make Open Enrollment types of changes to your coverage when you return to work. These changes will be effective immediately upon your return to work.

If you are absent for a full pay period (State biweekly employee) and your coverage was terminated, or you purchased **COBRA** coverage while on leave, you must file a new *NJ State Health Benefits Program Application* **within 60 days** of the first day of your return to work. In addition, filing your application as soon as possible upon your return to work will help to ensure a timely re-enrollment.

Workers' Compensation

If you have a Workers' Compensation award pending or have received an award of periodic benefits under Workers' Compensation or the Second Injury Fund, you and your dependents are entitled to have continued coverage at the same contribution level as when you were an active employee. You must remit to your employer, in advance, that portion or the premiums that you would normally pay, if any.

Medicare Parts A and B

It is not necessary for a **Medicare**-eligible employee or spouse to be covered by Medicare while they remain actively at work. It is required that they enroll in both Parts A and B prior to retirement so that coverage will be effective at the time of retirement.

RETIREE COVERAGE

The SHBP is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in the SHBP's **Retired Group** coverage. Early filing is recommended to prevent any lapse of coverage or delay of eligibility.

Medicare Coverage

IMPORTANT: A Retired Group member and/or dependent spouse who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP Retired Group coverage.

You will be required to submit documentation of enrollment in Medicare Parts A and B when you become eligible for that coverage. Acceptable documentation includes a photocopy of your Medicare card showing both your Part A and B enrollment or a letter from Medicare indicating the effective dates of both your Parts A and B coverage. Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions and Benefits, 50 West State Street, PO Box 299, Trenton, New Jersey 08625-0299. If you do not submit evidence of Medicare coverage under both Parts A and B, you and/or your dependents will be terminated from the SHBP. Upon submission of proof of **full Medicare coverage,** your coverage will be reinstated by the SHBP.

IMPORTANT: If a provider does not participate with Medicare, no benefits are payable under the SHBP for the provider's services.

A **Member** May be Eligible for Medicare for the Following Reasons:

— ***Medicare Eligibility by Reason of Age***

This applies to a **member** who is the employee or covered spouse and is at least 65 years of age.

A member is considered to be eligible for Medicare by reason of age from the first day of the month during which (s)he reaches age 65. However, if (s)he is born on the first day of a month, (s)he is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

The health plan is the secondary plan.

— ***Medicare Eligibility by Reason of Disability***

This applies to a member who is under age 65.

A member is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months.

The health plan is the secondary plan.

— ***Medicare Eligibility by Reasons of End Stage Renal Disease***

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member who is not eligible for Medicare because of age or disability may qualify because of treatment for End

Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when:

- The individual has group health coverage of their own or through a family member (including a spouse).
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The above rules, known as the Medicare Secondary Payer (MSP) rules are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time.

As of 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the MEDICARE eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a **"coordination of benefits"** period; and (3) a period where Medicare is **primary**.

Three-month waiting period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, the group health plan is primary.

Coordination of benefits period

During the "coordination of benefits" period, Medicare is secondary to the group health plan coverage. Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD after 1996, the coordination of benefits period is 30 months.

When Medicare is primary

After the coordination of benefits period ends, Medicare is considered the primary payer and the group health plan is secondary.

— ***Dual Medicare Eligibility***

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- If the health plan is primary because the member has active employment status, then the group health plan continues to be primary for 30 months from the date of dual Medicare entitlement.
- If the health plan is secondary because the member is not actively employed, then the health plan continues to be the secondary payer. There is no 30-month coordination period.

How to File a Claim If You Are Eligible for Medicare

When filing your claim, follow the procedure listed below that applies to you.

New Jersey Physicians or Providers:

— You should provide the physician or **provider** with your identification number. This number is indicated on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."

— The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.

— After Medicare has taken action, you will receive an *Explanation of Benefits* form from Medicare.

— If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to (name of your SHBP plan) for their consideration in processing supplementary coverage benefits."

— If the above statement does not appear on the *Explanation of Benefits,* you should indicate your Social Security number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed claim form and send it to the address on the claim form.

Out-Of-State Physicians or Providers:

— The *Medicare Request for Payment* form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.

— When you receive the *Explanation of Benefits,* indicate your identification number and the name and address of the physician or provider in the remarks section and send the *Explanation of Benefits* with a completed claim form to the address on the claim form.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage except for Medicare requirements as stated above.

Change of Coverage

To change your coverage you should contact the Office of Client Services at the Division of Pensions and Benefits and request a *SHBP Retired Status Application.* You are eligible to change and should change your coverage under the following circumstances.

— You marry and want to enroll your spouse.

— You need to enroll a new child.

— You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives at home, or turns age 23).

— You wish to change your medical plan. A **Retired Group member** can switch medical plans once in any 12-month period or when rates change.

— Your spouse's employment status changes resulting in a significant change in health coverage.

IMPORTANT: Retirees should immediately notify the Health Benefits Bureau of changes

in family status. (1) Deleting coverage for dependents may affect premium rates and, although claims for ineligible dependents cannot legally be paid, *premiums cannot be reduced until appropriate notification is provided to the Health Benefits Bureau*. (2) Failure to submit a *SHBP Retired Status Application* to remove from your coverage a deceased or ineligible spouse for whom you receive a Medicare Part B reimbursement will result in the need for you to reimburse all incorrectly paid amounts.

SPECIAL RETIRED GROUP RULES

Limitations on Enrolling Dependents and Changing Coverage

Eligible dependents can be added to Retired Group coverage upon initial enrollment of the retiree and within 60 days of a change of family status (marriage, birth of child, etc.) that made the dependent eligible. The family member will be enrolled retroactive to the date of eligibility.

If the application to add a spouse or dependent is not received within 60 days of the status change, there will be a minimum 2 month **waiting period** from the date the enrollment application is received until the member is covered — beginning the first of the month following the expiration of the waiting period. You may remove family members from coverage at any time. Decreases in coverage will be processed on a timely basis. **It is your responsibility to notify the SHBP of any change in family status.** If family members are not properly enrolled, claims will not be paid.

Effective Dates

The effective date of any change in which a dependent is added to coverage because of **marriage, birth, or adoption** is the first of the month in which the event occurred if the *Retired Status Application* is filed within 60 days of the event (marriage, birth, adoption, etc.) with the SHBP. If the *Retired Status Application* is not received within 60 days of the event by the SHBP, the effective date will be the first of the month following a full two-month waiting period from the date of receipt of the application.

You are responsible for notifying the Health Benefits Bureau of a coverage change due to **death or divorce**. The effective date is the first day of the month following the date of death or divorce. Any claims incurred or services provided after this date are ineligible for payment.

The effective date of **any other change or termination of coverage** is based on the billing cycle in which the change or termination is received. In most cases, if an application for a change is received before, for example, January 15, the effective date will be February 1. If the application is received after January 15, the effective date will be March 1. The effective date of any transaction may be delayed if the member fails to submit the appropriate application and supporting information on a timely basis.

End of Coverage

Your coverage under the Retired Group terminates if:

- — you formally request termination in writing, or by completing a *SHBP Retired Status Application;*
- — your retirement is canceled;

— your pension allowance is suspended;

— you do not pay your required premiums;

— your plan discontinues services in your area and you do not submit an application to the SHBP to change to another plan;

— you or your spouse do not provide proof of enrollment in Medicare Parts A and B when eligible for Medicare coverage;

— your former employer withdraws from the SHBP (this may not apply to certain retirees of education, police, and fire employers);

— your Medicare coverage ends;

— you die; or

— the SHBP is discontinued.

Once coverage is terminated you are not normally permitted to be reinstated.

Survivor Coverage

If you, the retired member, predecease your covered spouse and/or other covered eligible dependents, your surviving dependents may be eligible for continued coverage in the SHBP. Surviving dependents are generally notified of their rights to continued coverage at the time the Division of Pensions and Benefits is notified of the death of the retiree; however, they may contact the Division of Pensions and Benefits' Office of Client Services for enrollment forms or for more information. It is imperative that survivors notify the Division of Pensions and Benefits as soon as possible after your death because their dependent coverage ends on the first of the month after the date of your death.

COBRA COVERAGE

Continuing Coverage When it Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (**COBRA**) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see Duration of Coverage, on page 11), and the member must pay the full cost of the coverage plus an administrative fee. The member/dependent can increase his or her level of coverage, i.e., add dependents or elect coverage (s)he did not have as a member/dependent.

Leave taken under the federal and/or State Family Leave Act is no longer subtracted from your COBRA eligibility period.

COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll in any SHBP medical coverage and, if offered by your employer, State prescription drug coverage during the SHBP Open Enrollment period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the SHBP Open Enrollment period as an active employee. However, any time of non-participation in the benefit is counted toward your maxi-

mum COBRA coverage period. If the State Health Benefits Commission makes changes to the health insurance package available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member.
- Reduction in work hours.
- Leave of absence.
- Divorce or legal separation (makes spouse ineligible for further coverage).
- Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, or marriage.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence**.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if (s)he becomes eligible because of your **death or divorce**, or (s)he becomes ineligible for continued group coverage because of **marriage, attaining age 23, or moving out of the household**, or because you **elected Medicare as your primary coverage.**

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- notify you and your dependents of the COBRA provisions when you and your dependents are first enrolled;
- notify you, your spouse, and your children of the right to purchase continued coverage when they become aware of a COBRA event that causes a loss of coverage;
- send the *COBRA Notification Letter* and a *COBRA Application* within 14 calendar days of receiving notice that a qualifying event has occurred; and
- maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

- notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, or death has occurred or that your child has married, moved out of your household, or reached age 23 — notification must be given within 60 days of the date the event occurred;
- file a *COBRA Application* within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- pay the required monthly premiums in a timely manner; and
- pay premiums, when billed, retroactive to the date of group coverage termination.

Termination of COBRA Coverage

Your COBRA coverage through the SHBP will end when any of the following situations occur:

- your eligibility period expires;
- you fail to pay your premiums in a timely manner;
- after the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- you voluntarily cancel your coverage;
- your employer drops out of the SHBP;
- you become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective October 21, 1998, the State Health Benefits Commission adopted as policy, the federal mandate "Women's Health and Cancer Rights Act of 1998." The mandate requires that plans, which cover mastectomies, must cover breast reconstruction; surgery to produce a symmetrical appearance; prostheses; and treatment of any physical complications.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-federal government plans may elect certain exemptions from compliance with HIPAA provisions on a year-to-year basis.

Act Requirements

For the plan year that began January 1, 2000, all SHBP health plans will meet or exceed the federal requirements with the exception of mental health parity for the Traditional Plan and NJ PLUS. Parity requires that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

Mental Health Parity

The State Health Benefits Commission has filed an exemption from the mental health parity requirement with the federal Health Care Financing Administration for **calendar years** 2000 and 2001. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Traditional Plan and NJ PLUS will not change, with the exception for ***biologically-based* mental illness** (see page 48). Maximum annual and lifetime dollar limits for mental health benefits are outlined on page 37).

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* (COC) form, which verifies your group health plan enrollment and termination dates, is available through your payroll or human resource office, should you terminate your coverage.

PURCHASE OF INDIVIDUAL INSURANCE COVERAGE

Employees, retirees, and their dependents may purchase individual, direct payment coverage from their State Health Benefits Program (SHBP) health plan carrier if their loss of group health coverage is due to any reason other than voluntary termination. Note: failure to pay required premiums is considered voluntary termination.

Before considering a converted policy, New Jersey residents should first investigate coverage available under the provisions of the New Jersey Individual Health Coverage Program. Information about available policies can be obtained from the New Jersey Individual Health Coverage Board at the Department of Banking and Insurance. Carrier and rate information can be obtained by calling 1-800-838-0935 or at *www.njdobi.org*

If you are Medicare eligible you may qualify for a Medigap policy through the New Jersey Department of Health and Senior Services — State Health Insurance Program (SHIP). For more information, contact SHIP at 1-800-792-8820.

You will have 31 days from the end of your SHBP coverage to exercise your right to conversion.

EXTENSION OF BENEFITS

If you are disabled with a condition or illness at the time of your termination from the SHBP and you have no other group medical coverage, you may qualify for an extension of benefits for this condition or illness. If you feel that you may qualify for an extension of benefits please contact your claims administrator for assistance.

If the extension applies, it is only for expenses relating to the disabling condition or illness. An extension, under any SHBP plan, will be for the time a member remains disabled from any such condition or illness, but not beyond the end of the **calendar year** after the one in which the person ceases to be a **covered person**. During an extension there will be no automatic restoration of part or all of a lifetime benefit maximum.

CLAIM APPEAL PROCEDURES

You or your authorized representative may **appeal** and request that your health plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical nature. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical need, appropriateness of treatment, or experimental and/or investigational procedures.

Your initial appeal request may be taken over the phone. Any subsequent appeals must be filed in writing to the following inquiry address:

Horizon Blue Cross Blue Shield of NJ
PO Box 387, Dept. X
Newark, NJ 07101

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- employee's identification number;
- date(s) of service(s);
- provider's name and identification number;
- the specific remedy being sought; and
- the reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

If dissatisfied with a final health plan decision on a medical appeal, only the member or the member's legal representative may appeal, in writing, to the State Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf. Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

Appeals Coordinator
State Health Benefits Commission
PO Box 299
Trenton, NJ 08625-0299

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps (s)he may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request, within 45 days in writing to the Commission, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Failure to respond to the audit will result in the termination from coverage of eligible dependents. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated.

OVERVIEW OF PLAN BENEFITS

All benefits listed in this section may be subject to limitations and exclusions as described in subsequent sections. All pertinent parts of this handbook should be consulted regarding a specific benefit.

The Traditional Plan has three parts: **basic benefits, extended basic benefits,** and **major medical benefits.**

BASIC BENEFITS

Basic benefits cover certain **hospital** (or **facility**) **charges**, in full, as follows:

- Inpatient covered services at an approved acute care hospital.
- Services provided at a **skilled nursing facility** or **detoxification facility**.
- Services of salaried staff, including doctors, nurses, interns, and others.
- Supplies such as drugs, X-rays, bandages, oxygen, and laboratory and pathology services.

Outpatient covered services billed by an approved facility include:

- **Facility charges** for the treatment of **accidental injuries**.
- Dialysis.
- **Facility charges** for a covered **surgical procedure**.
- Application and removal of casts.
- Alcohol treatment and rehabilitation.
- Home health care.
- **Facility charges** for same-day **surgical centers**.

EXTENDED BASIC BENEFITS

Extended basic benefits cover certain **medical-surgical** or **professional charges** billed by an eligible provider and may include items such as surgical and anesthesia fees, X-rays, laboratory tests, and inpatient medical care. Services are reimbursed according to a fee schedule and are not subject to **deductibles** and/or **coinsurance**.

Basic benefits and **extended basic benefits** are either paid in full or according to a fee schedule on a **first-dollar basis**. That is, there is no deductible or required coinsurance and the first dollars paid against the claim come from the plan, not the member. If basic or extended basic benefits do not completely pay for an eligible charge, the remainder of the charge, with some exceptions, is then normally processed under the major medical portion of the plan.

MAJOR MEDICAL BENEFITS

Major medical benefits include eligible services not completely paid under the basic and

extended basic benefits, such as rehabilitation hospital care, outpatient treatment, prescription drugs, and doctor's office visits. Generally, eligible expenses are paid at 80 percent of **"reasonable and customary fees"** after you satisfy an annual deductible. A reasonable and customary fee is the maximum amount considered eligible for payment for a specific service under the plan. Greater detail concerning major medical benefits are found in the Major Medical section, beginning on page 34.

GENERAL CONDITIONS OF THE PLAN

The plan will pay only for **eligible charges**, which:

- are **medically needed** at the appropriate level of care for the medical condition (When there is a question as to medical need, the decision on whether the treatment is eligible for coverage will be made by Horizon BCBSNJ.);
- are listed in the "Eligible Services and Supplies" sections of this handbook;
- are ordered by a **doctor** (as defined by the plan) for treatment of illness or injury;
- were provided while you or your eligible family members were covered by the plan. (For example, if your coverage ended on August 31 and you were treated by a doctor for a broken leg on August 30, the doctor's bill is eligible even if you do not send it to Horizon BCBSNJ until some time after August 30. If, however, you were treated on September 1, the bill would not be eligible because you were not a member of the plan at the time the treatment was rendered.);
- are not specifically excluded (listed in the section *Charges Not Covered by the Plan* on page 53).

Reasonable and Customary Fees

The plan covers only **reasonable and customary (R&C) fees**, which are determined by the Prevailing Healthcare Charges System (PHCS) fee schedule. This schedule is based on actual bills charged by physicians in a specific geographic area for a specific service. If your physician charges more than the reasonable and customary fee, you will be responsible for the full amount above the R&C fee in addition to any deductible and **coinsurance** you may be required to pay.

Experimental or Investigational Treatments

The plan does not cover treatment that is considered experimental or investigational. Charges in connection with such a service or supply are also not covered. For the purpose of this exclusion, a service or supply will be considered experimental or investigational if the claims administrator determines that one or more of the following is true.

- The service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or set of **indications**. Clinical trials include but are not limited to phase I, II, and III clinical trials.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for a particular diagnosis or set of indications before it is used outside clinical trials or other

research settings. The claims administrator will determine this based on:

- published reports in authoritative medical literature; and
- regulations, reports, publications, and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

— It is a drug, device, or other supply that is subject to FDA approval but:

- does not have FDA approval for sale and use in the USA (that is, for introduction into and distribution in interstate commerce); or
- has FDA approval only under the Treatment Investigational New Drug regulation or a similar regulation; or
- has FDA approval, but is being used for an indication or at a dosage that is not an acceptable **off-label use**. Horizon BCBSNJ will determine if a use is an accepted off-label use based on published reports in peer-reviewed, authoritative medical literature and entries in the following drug compendia: The American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United State Pharmacopoeia Dispensing Information; or
- is an FDA-regulated product, service, supply, or drug under any FDA program other than FDA approval for introduction and distribution into interstate commerce.

— The provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval.

— The provider's institutional review board requires that the patient, parent, or guardian give an informed consent stating that the service or supply is experimental or investigational, part of a research project or study, or federal law requires such a consent.

— Research protocols indicate that the service or supply is experimental or investigational. This item applies for protocols used by the patient's provider as well as for protocols used by other providers studying substantially the same service or supply.

— The service or supply is not recognized by the prevailing opinion within the appropriate medical specialty as an effective treatment for the particular diagnosis or set of indications.

Predetermination of Benefits

Predetermination of benefits is required for organ transplants, with the exception of kidney and cornea. It is not required for any other services. A predetermination for any service may, however, be obtained *in writing* in advance of services being rendered. The written request will need to include the provider's name address and phone number, diagnosis, description of the services to be rendered, and the anticipated charges. Telephone contact with Horizon BCBSNJ or the Division of Pensions and Benefits about coverage does not constitute a predetermination of benefits. If the actual services rendered differ from those described in the written request, the predetermination of benefits will have no effect.

Maintenance Care

The Traditional Plan does not provide coverage for services that are determined to be for **maintenance** or **supportive care**. Maintenance care is defined as care given to reduce the incidence or prevalence of illness, impairment and risk factors and to promote optimal function. Maintenance treatments are considered to be not medically needed and are therefore, not eligible for coverage. Supportive care is defined as treatment for patients having reached maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains that would otherwise progressively deteriorate. In some instances chiropractic care or physical therapy may be clinically appropriate (such as treatment of a chronic condition that requires supportive care) yet it would not be eligible for reimbursement under the Traditional Plan.

Discounted Providers

If you live in New Jersey, Pennsylvania, or New York, you may be able to take advantage of a Horizon BCBSNJ special program. In this program, **participating providers** contract with Horizon BCBSNJ for a discounted fee schedule. When you use a participating provider, the Traditional Plan will pay the provider. You will pay the provider your 20 percent coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. In addition, participating providers submit all claims directly to Horizon BCBSNJ, eliminating the necessity of claim forms. To find out if your provider participates in the network, call 1-800-414-SHBP (7427).

Other BCBS plans throughout the country have similar arrangements with providers in their areas of coverage. Traditional Plan members and their covered family members are eligible to take advantage of the savings offered by using these participating providers. Contact the local BCBS plan in the area where you reside to identify participating providers.

Appeals

You have the right to formally **appeal** to Horizon BCBSNJ if you disagree with a claim decision or predetermination of benefits. You then have the right to appeal Horizon BCBSNJ's final decision to the State Health Benefits Commission, but it is your responsibility to demonstrate that the particular treatment falls within the terms and conditions of the plan. For more information on the appeals process, please refer to the "Appeals" section.

PRESCRIPTION DRUG BENEFITS

The State Health Benefits Commission requires that all employees and retirees and their dependents who are enrolled in the State Health Benefits Program have access to prescription drug coverage. If you are retired or if you are employed by a county, municipality, board of education, or other local public employer that does not offer a separate prescription drug plan to its employees, all plans offered through the SHBP, including the Traditional Plan, must include a prescription drug benefit. If you have prescription drug coverage through your employer or through the SHBP Employee Prescription Drug Plan, the SHBP plans including the Traditional Plan will not provide prescription drug coverage.

Active Employees (Whose employer does not provide prescription drug coverage)

Active employees who have prescription drug coverage through the Traditional Plan have

access to a discounted prescription drug reimbursement program through the major medical benefits. By presenting your discount prescription card to the pharmacist you are charged a reduced fee, and the claim is electronically submitted to Horizon BCBSNJ for consideration. After deductibles are met the Traditional Plan will pay 80 percent of the prescription cost.

State active employees have a free standing prescription drug plan called the Employee Prescription Drug Plan and do not have prescription drug coverage through the Traditional Plan.

Retirees

As of January 1, 2000, a separate prescription drug card program with a co-payment design was introduced for retirees enrolled in the Traditional Plan. The Retiree Prescription Drug Plan includes a mail order service for maintenance medications. All retiree prescriptions filled after January 1, 2000 will be administered through the Retiree Prescription Drug Plan and will not be reimbursed through the Traditional Plan. Prescription drug co-payments from the SHBP Retiree Prescription Drug Plan or other group plans are not reimbursable through the Traditional Plan. The following copayment amounts are applied to prescriptions purchased through the Retiree Prescription Drug Plan:

Retail Pharmacy - up to a 90-day supply copayment amounts

Supply	Generic	Preferred Brand	Non-preferred Brand
01-30 days	$5	$10	$20
31-60 days	$10	$20	$40
61-90 days	$15	$30	$60

Mail Order - up to a 90-day supply copayment amounts

Generic	Preferred Brand	All Other Brands
$5 copayment	$15 copayment	$25 copayment

There is a $300 annual maximum in prescription drug copayments per person. Once a person has paid $300 in copayments in a calendar year, that person is no longer required to pay any prescription drug copayments for the remainder of that calendar year. Prescription drug copayments are not eligible for reimbursement and do not apply to the Traditional Plan deductible or coinsurance. Please note that over 99 percent of the pharmacies in New Jersey and 95 percent nationally participate with PAID Prescriptions. In the event a pharmacy does not participate with PAID Prescriptions, you should pay for the prescription and file a claim with: PAID Prescriptions, P.O. Box 723, Parsippany, NJ 07054-0723.

COORDINATION OF BENEFITS

Almost all group insurance programs, including the Traditional Plan, provide for the **coordination of benefits** (COB). A program without such a provision is automatically the primary program whenever its benefits are duplicated.

Please note: The COB rules may change if Medicare is involved. Please refer to the Medicare section on page 6 for more information.

For group programs that do have a COB provision, the following rules determine which is the primary program.

— If you are the patient, the Traditional Plan is the primary program. If your spouse is the patient, and covered under a program of his or her own, then that program is the primary program.

— If a dependent child is the patient and is covered under both parents' programs, the following **birthday rule** will apply.

  Under the **birthday rule**, the plan covering the parent whose birthday falls earlier in the year will have primary responsibility for the coverage of the dependent children. For example, if the father's birthday is July 16 and the mother's birthday is May 17, the mother's plan would be the primary program for the couple's dependent children because the mother's birthday falls earlier in the year. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary.

  This birthday rule regulation affects all carriers and all contracts which contain COB provisions. It applies only if both contracts being coordinated have the birthday rule provision. If only one contract has the birthday rule and the other has the gender rule (father's contract is always primary), the contract with the gender rule will prevail in determining primary coverage.

  If two or more programs cover a person as a dependent child of separated or divorced parents, benefits for the dependent child will be determined in the following order.

  - The program of the parent with custody is primary; followed by
  - he program of the spouse of the parent with custody of the child; then
  - the program of the parent not having custody of the child.
  - If it has been established by a court decree that one parent has responsibility for the child's health care expenses, then the program of that parent is primary.

— The benefits of the program which covers a person as an active employee or his/her dependents will be determined before the benefits of a program which covers such person as a laid-off or a Medicare-eligible retired employee or his/her dependents. If the other benefit program does not have this rule and, as a result, do not agree on the order of benefits, this rule will not apply. If none of the above rules determine the order of benefits, the program that has covered the patient for the longer period is the primary program.

The Traditional Plan will provide its regular benefits in full when it is the **primary plan**. As a secondary plan, the Traditional Plan will provide a **reduced amount** which when added to the benefits under other group plans will equal up to **100 percent** of the **eligible charges**.

If you and your dependents have NJ PLUS as a secondary program, you may utilize that cov-

erage as primary to receive services from a Primary Care Physician, Chiropractor or Obstetrician/Gynecologist.

Please note: There is no coordination of benefits for medical charges if both you and your spouse, through separate employers in the SHBP, have selected the Traditional Plan as your primary plan under the SHBP. Please refer to the enrollment section of the "General Information" section of the *SHBP Summary Program Description* for more detailed information.

BASIC BENEFITS - HOSPITALIZATION

Bills for eligible inpatient care provided by a **hospital** are usually paid in full through a combination of basic and major medical benefits. If you or a covered family member is admitted to a Blue Cross Blue Shield (BCBS) **member hospital** in New Jersey, the hospital will electronically transmit its bill to Horizon BCBSNJ. If you enter an **out-of-state hospital** that has a contract with BCBS, the hospital will send the bill electronically through the **Blue Card Program**; which will forward it to Horizon BCBSNJ for payment. If you use a hospital outside of New Jersey that does not have a contract with the local BCBS, you or the hospital should send the bill to Horizon BCBSNJ. What is not paid by the hospital benefits part of the Traditional Plan may be automatically considered under the major medical part of the plan.

To qualify for benefits under the Traditional Plan, hospital charges must be considered eligible and provided in a facility that meets the SHBP definition of a hospital.

COVERAGE IN THE HOSPITAL

The hospital benefits of the Traditional Plan cover up to 365 days in a hospital per **calendar year**. When an individual is hospitalized, (s)he begins working against the 365-day maximum. If (s)he is released from the hospital but is readmitted in the same calendar year, (s)he continues to work against that year's 365-day maximum. At the beginning of the next calendar year, the 365 benefit days renew or start over, providing the individual was released from the hospital and has not been readmitted for the same or related conditions for at least 90 days.

For example:

Example 1: A person hospitalized for 65 days is released from the hospital in June 1999. The person is hospitalized again beginning in February 2000. In February, a new 365-day period begins to run because a new calendar year has started and the person has stayed out of the hospital for 90 days between admissions.

Example 2: A person is hospitalized for 65 days and is released on December 3, 1999. On January 15, 2000, the person is readmitted for the same condition that was treated in the previous hospitalization. Since the person was not out of the hospital for 90 days, a new 365-day period is not begun. These days will be counted against the 1999 days with the first day in the hospital counting as day 66 of the 1999 days.

Example 3: A person leaves the hospital on December 1, 1999. (S)he is hospitalized again on January 3, 2000 but for a condition unrelated to the previous hospitalization. Since the person was not in the hospital at the start of the calendar year and (s)he has not been hospitalized *for this condition* for over 90 days, a new 365-day period begins to run on January 3.

After the 365-day maximum has been reached for a particular person, coverage under hospital benefits stops. Medically-needed hospital expenses can continue to be covered under the major medical portion of the plan subject to the total lifetime maximum.

IMPORTANT: If an individual is so seriously ill as to require extensive,

long-term hospitalization, Voluntary Case Management, described on page 51, should be considered.

HOSPITAL INPATIENT

Eligible Services and Supplies

The following items provided during inpatient care are eligible under the hospitalization portion of the Traditional Plan.

- Bed and meals in a semiprivate room.
- Intensive or special care units when **medically necessary**.
- Services of all hospital employees including hospital nurses (excluding private duty nursing), interns, residents, physicians assistants, technicians, or independent contractors who are paid by the hospital to provide the services rendered.
- Use of the operating, recovery, treatment, delivery, and/or emergency room.
- Dressings, bandages, oxygen, and plaster casts.
- Drugs and medicines that are administered in the hospital and have been approved by the federal Food and Drug Administration for use by the general public (experimental drugs are not eligible).
- Physical therapy while you are a hospital inpatient.
- Diagnostic X-rays, radioactive isotope studies, and laboratory and pathology services. (If you receive a separate radiology or pathology bill, forward it to Horizon BCBSNJ for consideration under the major medical portion of the plan.)
- Services provided by a hospital or nonprofit blood supplier for drawing, processing, or distributing blood (the cost of blood is not covered).
- Lenses implanted during cataract surgery; in-hospital use of crutches, traction devices and orthopedic devices.
- Surgically implanted cardiac pacemakers, including batteries, electrodes and their replacements.
- All other necessary services and supplies furnished by the hospital except for take-home items and patient convenience items (such as telephone, television, haircuts, guest meals, etc.).

HOSPITAL OUTPATIENT

Eligible Services and Supplies

The following items provided in a hospital outpatient department are eligible under the hospitalization portion of the Traditional Plan.

- **Accidental injury** treatment.
- Alcohol and **substance abuse** treatment services.
- Application and removal of plaster casts.

— Blood transfusions (not including the charges for whole blood), paracentesis, and/or thoracentesis.

— Cardiac pacemaker follow-up examinations.

— Chemotherapy, pathology, physical therapy, X-rays (diagnostic), and X-ray therapy (up to the same limits as covered under **extended basic benefits**).

— Dialysis treatment.

— Home hemophilia treatment.

— Poisoning treatment.

— Removal of implanted orthopedic hardware.

— Screening mammograms.

— Surgery of a cutting or cauterizing nature (except for chemical cauterization).

— Approved surgical diagnostic procedures. Call 1-800-414-SHBP (7427) if you need to know if a specific **surgical procedure** will be covered under this provision.

OTHER HOSPITAL SERVICES

Alcohol and Substance Abuse Benefits - Inpatient

Eligible alcohol and substance abuse treatment services are covered like any other general illness under the plan.

Birthing Centers

As an alternative to the conventional hospital delivery room care for low-risk maternity patients, the hospitalization portion of the Traditional Plan pays for care provided in birthing centers under contract to Horizon BCBSNJ. Services routinely provided by the birthing centers, including prenatal, delivery, and postnatal care, will be covered in full under the basic benefits portion of the plan, if the delivery takes place at the center. If complications occur during labor and delivery occurs in an approved hospital because of the need for **emergency** or inpatient care, this care will also be covered in full. If the delivery does not occur at the center, or if the care of the patient transfers to a hospital maternity program, all expenses incurred at the center for prenatal care will be considered under the major medical portion of the plan.

Contact Horizon BCBSNJ at 1-800-414-SHBP (7427) to identify eligible birthing centers near you. If you do not reside in New Jersey, call your local BCBS for eligible birthing centers it has under contract.

Dental Benefits - Inpatient

Dental care under the Traditional Plan is very limited. The basic benefits portion of the plan may provide coverage for inpatient and outpatient hospital bills related to any of the services listed below.

— Removal of bony impacted molars.

— The treatment of accidental injuries caused by a traumatic event excluding dam-

age caused by chewing.

- Treatment for mouth tumors if **medically necessary**.
- **Medically necessary** hospital and anesthesia charges incurred for dental services for severely disabled members and children who can submit convincing documentation for the medical need for the hospitalization/anesthesia services. Charges for the actual dental procedures would not be eligible for benefit consideration.

Dialysis

Dialysis is covered when the services are provided and billed by an eligible hospital, by a separate dialysis center, or by an eligible **home health agency**. The facility must make arrangements for training, equipment rental, and supplies on behalf of the patient.

If the dialysis center is not under contract with Horizon BCBSNJ, the charges will be considered under the major medical portion of the plan.

Federal Government Hospitals

The Traditional Plan will pay hospitals operated by the United States government (Veterans Administration and Department of Defense) as if they were member hospitals, regardless of their location, for military patients (military retirees and their dependents and dependents of active duty military personnel), for **eligible charges** for nonmilitary conditions.

The Traditional Plan will pay hospitals operated by the United States government for nonmilitary patients (i.e., patients other than military retirees and their dependents and dependents of active duty military personnel) for eligible charges only if:

- services are for treatment on an **emergency** basis for **accidental injury** from an external cause; or
- services are provided in a hospital located outside of the United States and Puerto Rico.

Home Health Care Agency Benefits

The hospitalization portion of the Traditional Plan covers home health visits as long as the circumstances meet plan guidelines. Members receiving home health care must be home-bound and must require skilled nursing care, physical therapy, or speech therapy under a plan prescribed by an attending physician and approved by Horizon BCBSNJ. Eligible home health services provided by an approved participating home health agency include:

- Part-time skilled nursing services provided by or under the supervision of a registered professional nurse (RN).
- Physical therapy.
- Speech therapy - see speech therapy plan guidelines on page 50.
- Any other related treatment and services eligible for hospital benefits, except drugs and administration of hemodialysis.
- Medical social services or part-time services by a home health aide during the period when you are receiving eligible skilled nursing care, physical therapy or speech therapy services.

Up to 60 visits are available within 61 days per occurrence. Every three home health care visits by a participating Horizon BCBSNJ home health care agency reduces your available inpatient days by one (1). A prior inpatient hospital stay is not required to qualify for home health agency benefits, however, your provider must contact CareAdvantage, Inc. at 1-800-624-1294 in order to certify benefits through a participating agency prior to services being rendered. Benefits are not available for services rendered by a non-participating home health care agency.

Home health care services that are deemed "custodial" by Horizon BCBSNJ will not be eligible for benefits under the Traditional Plan. Custodial services are primarily services rendered that do not require the skill level of a nurse for performance. These services include but are not limited to activities of daily living (ADLs): such as bathing, meal preparation, dressing, feeding, aiding in ambulation, cleaning, and laundry functions.

Home Hemophilia Treatment

Home hemophilia treatment will be considered when there is documented medical evidence that these services cannot be performed in an outpatient facility

Hospice Care Benefits

Benefits for hospice care must be provided according to a physician prescribed course of treatment approved by Horizon BCBSNJ with a confirmed diagnosis of terminal illness and a life expectancy of six (6) months or less.

The following hospice services are covered.

- Part-time professional nursing services of an R.N. or L.P.N.
- Home health aide services provided under the supervision of an R.N.
- Medical care rendered by a hospice care program physician.
- Therapy services (including speech, physical, and occupational therapies).
- Diagnostic services.
- Medical and surgical supplies (with prior authorization) and **durable medical equipment**.
- Prescribed drugs.
- Oxygen and its administration.
- Up to 10 days for respite care.
- Inpatient acute care for related conditions.
- Medical social services.
- Psychological support services to the terminally ill patient.
- Family counseling related to the eligible person's terminal condition.
- Dietician services.
- Inpatient room, board, and general nursing services for related conditions.

No benefit consideration will be given for any of the following hospice care benefits.

- Medical care rendered by the patient's private physician (these services would be paid under major medical).

— Volunteer services.
— Pastoral services.
— Homemaker services.
— Food or home-delivered meals.
— Non-authorized private-duty nursing services.
— Dialysis treatment.
— Services that are not billed by and payable to an eligible hospice provider.
— Bereavement counseling.

Hospice care benefits are not limited to or counted against the benefit days available under the hospitalization portion of the Traditional Plan. Inpatient benefits for hospice patients are provided at the same level as those provided for non-hospice patients. For more information on hospice care, please call CareAdvantage, Inc., at 1-800-624-1294.

Mastectomy

Hospital charges related to mastectomy services are covered as follows, unless the patient and physician determine that a shorter stay is medically appropriate:

— a minimum of 72 hours inpatient care following a modified radical mastectomy; or
— a minimum of 48 hours following a simple mastectomy.

Mental Health Benefits - Inpatient

Up to 20 inpatient days for the treatment of non-biologically based mental, psychoneurotic or personality disorders are covered. These days are renewed every **calendar year** provided that the patient has not been readmitted to the hospital for at least 90 days for related illnesses.

For example: You use 20 mental health days and are discharged on November 1, 2000. Your new 20 inpatient benefit days do not start until 90 days have elapsed from November 1, 2000, therefore, you would not be eligible for new 20 inpatient benefit days in 2001 until February 1, 2001.

Once the 20 inpatient benefit days have been exhausted, any additional inpatient days and all in-hospital medical services will be considered under the major medical portion of the Traditional plan, subject to the deductible, coinsurance, and annual and lifetime mental health maximum benefits. Please refer to page 48 for more information on available **major medical benefits** for mental health conditions.

Services rendered for the treatment of a **biologically based mental illness** are treated like any other illness and are not subject to the 20-day maximum. Biologically based mental illness includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Obstetrical Care Benefits - Inpatient

Hospital and delivery charges related to the mother's obstetrical care and the newborn child's and mother's initial stay in the hospital are covered. The plan will provide coverage for a minimum of 48 hours of inpatient care for the mother and newly born child following a vaginal deliv-

ery and up to 96 hours following a cesarean section. If a doctor orders care beyond the 48/96 hours, medical necessity documentation will be required in order to determine continuing benefits.

In some instances, the plan will also pay bills related to the birth of a grandchild. In order for benefits to be available, **all** of the following must apply:

- the mother must be enrolled as a dependent
- the mother resides with the member and must be substantially dependent on the member for support and maintenance;
- the mother is under the age of 23 and unmarried.

Coverage for the grandchild ends when the mother is discharged from the hospital. The grandparent may apply for coverage of the grandchild under the SHBP only if (s)he obtains legal custody of the child. The mother may apply for COBRA coverage for the newborn.

Organ Transplants

The following human organ transplant procedures are eligible for coverage only with prior written pre-certification by Horizon BCBSNJ:

- Heart
- Lung
- Heart-lung
- Pancreas
- Liver
- Certain bone marrow transplants.

The following human organ transplant procedures are eligible for coverage without pre-certification by Horizon BCBSNJ:

- Cornea
- Kidney

If your physician has recommended a human organ transplant procedure, call 1-800-414-SHBP (7427) to obtain information on pre-certification.

Services billed by an approved hospital that participates in the Blue Quality Centers for Transplants (BQCT) network for human organ transplant procedures are covered. The plan also provides coverage for the cost of transportation and storage services directly related to the donation of the organ and billed by a BQCT network hospital.

If you choose to use a hospital that is not part of the BQCT network, you may be responsible for 20 percent of some charges.

In the absence of other insurance, charges incurred by the organ donor that are directly related to the transplant will be considered for coverage under this plan.

Benefits are available for surgical services in connection with eligible human organ transplants when provided by and billed by a physician.

Pre-admission Testing

Diagnostic tests that would normally be a part of a hospital stay will also be paid by the plan if they are performed on an outpatient basis by a hospital that participates in the Horizon BCB-SNJ pre-admission testing program.

Pre-admission testing is covered at 100 percent only if you are scheduled for admission to a participating hospital for treatment of the diagnosed condition that made the pre-admission test(s) necessary. The testing will also be covered if the admission is postponed or canceled for one of the following reasons:

- The tests show a condition requiring medical treatment before the admission.
- A medical condition develops, delaying the admission.
- A hospital bed is not available on the scheduled date of admission.
- The tests indicate that the admission is not necessary.

Pre-admission testing performed at a nonmember facility is not covered under hospital benefits. It will, however, be covered under the major medical part of the plan.

Private Rooms

If you occupy a private room in a hospital, you must pay the difference between the private room rate and the average semiprivate room rate.

Surgical Centers

If **surgical procedures** are provided in an eligible **surgical center** instead of a **hospital**, the hospitalization portion of the plan will provide 100 percent coverage for **facility charges** as long as you are admitted and discharged within a 24-hour period and the center is under contract with any BCBS Plan.

Ophthalmic Surgical Centers

Facility fees for certain services provided by an outpatient ophthalmic surgical center as an alternative to hospital inpatient or outpatient surgery are covered. Only the following cataract surgical procedures are eligible.

- Extraction of lens with or without iridectomy; intracapsular, with or without enzymes.
- Intracapsular, for dislocated lens.
- Extracapsular.
- Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure).
- Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure).
- Insertion of intraocular lens subsequent to cataract removal (separate procedure).

The following criteria must be met for the facility fee to be covered.

- The facility must be approved by the Health Care Financing Administration (HCFA);

— The Horizon BCBSNJ payment is accepted as payment in full for the facility charge; and

— The facility charge is separate from the physician's charge.

Skilled Nursing Facility

A **skilled nursing facility** is a specific type of treatment center that falls midway between a **hospital** (which provides care for acute illness) and a nursing home (which primarily provides assistance with daily living). *The Traditional Plan does not pay for nursing home care.* Hospitalization coverage does, however, cover *up to 30 days* of care in a skilled nursing facility when it is under a plan prescribed by a doctor and approved by Horizon BCBSNJ. The plan's payment to the member skilled nursing facility will be accepted as payment in full. Room and board charges beyond 30 days are not covered under **major medical benefits**. Any charges, other than room and board charges, not eligible under the hospitalization coverage, will be considered under the major medical portion of the plan.

You may be transferred to a member skilled nursing facility directly from your home or from a hospital if your physician prescribes that you need skilled care, therapeutic services, and treatment for your illness or injury.

Skilled nursing facility services include:

— Semiprivate accommodations

— Up to 30 benefit days during each admission

— The same covered services that are available to hospital inpatients as described in this handbook, but only if they are available at the member skilled nursing facility (e.g., physical therapy, medications, etc.).

If Medicare pays for some skilled nursing facility days, they will be counted as part of the same covered 30-day period.

Skilled nursing facility room and board charges are not covered under major medical benefits. Charges for eligible medical services (such as medications, physical therapy, etc.) provided while the patient is confined in a skilled nursing facility will be considered for major medical benefits.

EXTENDED BASIC BENEFITS - MEDICAL-SURGICAL

Medical-surgical benefits include a specific set of covered professional services and supplies billed by a doctor that are paid according to a fee schedule on a **first-dollar basis**. This means that the charge, if eligible, is paid up to the level of the fee schedule with no **deductible** considered. The remaining amount above the level of the fee schedule would then be considered under the major medical portion of the plan.

MEDICAL-SURGICAL

Eligible Services and Supplies

Specific amounts payable under medical-surgical benefits are shown below. Any **eligible charges** above those amounts are eligible for consideration under the major medical portion of the plan.

— Chemotherapy: up to $500 per **calendar year** for chemotherapy performed outside a hospital following surgical treatment for breast cancer.

— Dental: up to $264 for the removal of bony impacted molars or impacted bicuspids if done in a hospital ($105 for the first tooth and $53 for each of the next three teeth); Any remaining balance **will not be** considered under the major medical portion of the plan.

— Newborn well-care: up to $42 for care of a healthy newborn child while both mother and child are hospitalized; Any remaining balance **will not be** considered under the major medical portion of the plan.

— Pathology, laboratory examinations, electroencephalograms, and other clinical tests performed outside a hospital: $25 per calendar year;

— Physicians' services for surgical procedures: up to a fixed amount for specific surgical procedures.

For example:

Cesarean Section	$651
Total Hysterectomy	$578
Obstetrical Care	$420
D&C	$126
Appendectomy	$368
Repair Inguinal Hernia	$315

— Physical therapy: up to $50 per calendar year for physical therapy performed outside a hospital.

— Radioactive isotope studies: up to $125 per calendar year for radioactive isotope studies wherever performed.

— Radioactive isotope therapy: up to $500 per calendar year for radioactive isotope therapy wherever performed.

— Radium, radioactive isotope (sealed sources), or radon therapy: $150 per calendar year for radium, radioactive isotope (sealed sources), or radon therapy.

— Shock therapy: up to a fixed fee schedule amount for electroshock, insular shock, or similar shock treatments given for mental, psychoneurotic, or personality disorder.

— X-rays (diagnostic): up to $125 per calendar year for diagnostic X-rays performed, other than inpatient.

— X-ray therapy: up to $500 per calendar year for X-ray therapy performed, other than inpatient.

Benefit Examples

Example 1: You have several diagnostic X-rays done outside of a hospital and the total charges are $300. The first $125 is paid in full under **basic benefits** and the remaining $175 is considered under the major medical portion of the plan.

Example 2: You have a cesarean section done and the obstetrician charges you $800. The first $651 is paid in full under basic benefits and the remaining $149 is considered under the major medical portion of the plan.

SERVICE BENEFITS

If you are covered in the **Active Group** and meet the income limitations below, the Traditional Plan will pay 100 percent of the doctor's bills for certain basic benefit services, such as surgery, anesthesia, and inpatient medical charges. This provision does not apply to **Retired Group members.**

— If you are unmarried, with single coverage, you must have a gross annual income of less than $14,000; or

— If you have member and spouse, parent and child, or family coverage, the combined gross annual income of you and your spouse (if any) must be less than $20,000.

Gross annual income means salary, wages, business profits, interest, dividends and income from all sources. In determining if the 100 percent benefit is available, the plan administrator will consider gross annual income in the calendar year before the service was rendered.

In both instances, the 100 percent payment provision is subject to all other plan provisions, such as medical necessity and **reasonable and customary fees**. You are responsible for notifying the plan when you qualify for service benefits within 90 days of the service.

MAJOR MEDICAL BENEFITS

GENERAL

The Traditional Plan includes coverage for major medical services provided by doctors and other medical professionals. The provider must meet the SHBP definition of doctor or hospital or other approved provider for charges to be covered.

MAJOR MEDICAL

Services and Supplies

The following services are included under the major medical portion of the Traditional Plan.

- Ambulance use for local emergency transport. Transport by invalid coach is not covered.
- Anesthetics and their administration.
- Breast prostheses following reconstructive breast surgery.
- Doctor's services for **surgical procedures** and for diagnosis and treatment of illness and injury.
- Eligible supplies, including surgical dressings, blood and blood plasma, artificial limbs, larynx and eyes, casts, splints, trusses, braces, crutches, respirator, oxygen and rental of equipment for its use.
- Hospital room and board for a semiprivate room. If you are in a private room, the plan will pay the semiprivate room rate and you must pay the difference. If the hospital has no semiprivate rooms, the plan will pay up to 80 percent of the hospital's lowest private room rate.
- Other supplies and nonprofessional services furnished by the hospital for medical care in the hospital, for example, operating room, X-rays, medicines, laboratory tests, and similar charges.
- Prescription drugs dispensed by a licensed pharmacist and approved by the FDA for sale and use in the United States at the dosage and for **indications** as approved by the FDA (see page 19 for additional information).

  Note: *Prescription drug coverage is not available through the Traditional Plan if a separate prescription drug card plan, including the SHBP Prescription Drug Card Program, is offered through the employer (see page 19 for more information).*
- Private duty professional nursing under very strict standards. Private duty nursing must be ordered by a doctor and provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) other than you, your spouse, or a child, brother, sister, or parent of you or your spouse. Private duty nursing will only be covered under extraordinary circumstances upon evidence of a clear and convincing objective need. Private duty nursing coverage will not be covered if the care is:

- **custodial care** (or assistance in the **activities of daily living** in a home, hospital, or facility of any kind); or
- normally provided by or should be provided by hospital nursing staff; or
- rendered by or could be provided by home health aides or any other nurses aides.

— Scalp hair prostheses prescribed or authorized by a doctor, but only if they are furnished in connection with hair loss resulting from:
- treatment of disease by radiation or chemicals;
- alopecia universalis (totalis); or
- alopecia areata.

The maximum amount that will be paid for any one person during a 24-month period is $500.

— Therapy provided by a qualified speech therapist as described below:
- Speech therapy to restore speech after a loss or impairment of a demonstrated previous ability to speak. To qualify under (a), the loss or impairment must not be caused by a mental, psychoneurotic, or personality disorder. Examples of non-covered therapy are that which is provided to correct pre-speech deficiencies and therapy provided to improve speech skills that have not fully developed.
- Speech therapy to develop or improve speech after surgery to correct a defect that both (1) existed at birth or (2) impaired, or would have impaired, the ability to speak. In addition, speech therapy services will be considered eligible for a period of one year for children with a documented medical history of multiple cases of Otitis Media and one or more myringotomy(ies).

— Treatment by a licensed physical or occupational therapist. The actual disease must be clinically demonstrated and therapy must be of proven value in the treatment of the condition. An example of physical or occupational therapy not covered is that which is provided for a learning or developmental disability and which is educational in purpose or **maintenance care** (see page 19).

— Treatment by X-ray, radium, or any other radioactive substance.

— Treatment due to **accidental injury** to natural teeth and dental prostheses replacing accidentally injured teeth (see Dental Care on page 41 for limitations).

— X-rays and lab exams when **medically necessary**.

MAJOR MEDICAL PAYMENTS

Deductibles

The major medical portion of the plan has an annual **deductible** of $100, which means that it is your responsibility to pay the first $100 in eligible medical bills each year. Expenses for ineligible services and charges in excess of reasonable and customary fees do not count toward

your deductibles. The actual deductible amount per person varies with the type of coverage you have:

- Single - $100.
- Member and Spouse - $100 per person.
- Parent and Child(ren) - $100 for you and $100 for any one other child.*
- Family - $100 for you and $100 for one other family member.*

If two children each have $50 in bills, the $100 deductible for other family members has not been reached. If one child has $110 in eligible bills, then the $100 deductible for other family members has been reached and **eligible charges for treatment of your spouse or other children would be eligible for payment at 80 percent).*

The year in which the deductible is measured runs from January 1 to December 31. However, if treatment for an illness or injury is provided during the last three months of the year, those eligible charges that were applied toward a deductible may be counted toward meeting the deductible for the following year.

Additionally, if two or more family members are injured in the same accident, then your family must meet only one deductible of $100. For instance, your house is damaged in a tornado and three of your family members are treated by a physician at a cost of $50 each in eligible charges, for a total of $150. The $100 deductible has been met, and the other $50 will be considered under the major medical plan.

If you are enrolling for the first time in the State Health Benefits Program because your employer has decided to join, bills that would have been eligible if your employer had been in the program for the current **calendar year** can be used to meet the deductible requirements.

For example: You work for a city that is joining the SHBP on July 1. Your employer's prior insurance plan had a deductible of $200 and you have already paid $200 for yourself and $100 for one child. When you join the program on July 1, you will be considered to have met the deductible for yourself and for other family members for that calendar year. You must submit documentation to Horizon BCBSNJ showing charges used to meet the deductible.

Coinsurance

Under the major medical portion of the Traditional Plan, you are required to pay 20 percent of the cost of eligible charges until you reach your out-of-pocket maximum (the point at which the eligible charges for the year total $2,000 after deductibles). Once an individual reaches his/her $2,000 ceiling, the plan will pay 100 percent of the reasonable and customary cost of treatment that is medically needed. Since the **coinsurance** applies to each person in your family, the actual amount you are required to pay each year will depend on the number of dependents on your coverage. Expenses for ineligible services and charges in excess of reasonable and customary fees do not count toward your out-of-pocket maximums.

For example:

Example 1: You have employee only coverage. You pay the first $100 (the

deductible) and 20 percent of the next $2,000 (or $400) of eligible charges. After you have spent a total of $500 (the $100 deductible and the $400 in coinsurance), the plan will pay 100 percent of any other eligible charges in that year.

Example 2: You have employee and spouse coverage. You pay the first $100 (the deductible) for you and your spouse and 20 percent of the next $2,000 in eligible charges for each of you ($400 apiece or $800). After you have reached the $500 limit for each person, the plan will pay 100 percent of any other eligible charges for each person for the year. The maximum that you might need to pay for deductibles and coinsurance is $1,000 ($100 deductible + $100 deductible + $400 in coinsurance + $400 in coinsurance).

Example 3: You have family coverage. You pay the first $100 (the deductible) for you and any one other family member (only one other member, but if two children each have $50.00 in bills, the $100 for other family members has not been met). If one other family member has over $100 in eligible charges, then the deductible for all the other family members has been met and bills for treatment of your spouse and/or other children would be eligible for payment at 80 percent. In addition to the two deductibles, you are responsible for up to $400 in coinsurance for each person. After each person meets that level, the plan will pay 100 percent of any other eligible charges for each person for the year.

LIFETIME BENEFIT MAXIMUM

The individual lifetime maximum for all benefits paid under the major medical portion of the Traditional Plan is **one million dollars** subject to an automatic limited restoration feature.

If your coverage under the Traditional Plan ends and begins again at a later date, your individual lifetime maximum benefit resumes at the same level it was when your coverage ended.

Mental Health Maximums

The individual mental health maximums for members not diagnosed with **biologically based mental illnesses** are as follows:

- A maximum of **$10,000** in major medical expenses will be paid in any one calendar year for the treatment of mental, psychoneurotic, or personality disorders.
- A lifetime maximum of **$20,000** will be paid for the treatment of mental, psychoneurotic, or personality disorders. Each member has **$20,000** in initial benefits and then an additional maximum of **$20,000** is available under the mental health automatic restoration of benefits.

Automatic Restoration of Benefits

The major medical portion of the Traditional Plan contains a unique restoration provision that can restore benefits once the maximum lifetime benefits or mental health benefits have been exhausted. At the start of each calendar year any previously unused portion of a **covered person's** maximum will be restored for future charges up to the lesser of $2,000; or the dollar amount needed to restore the full maximum.

Restoration will be made when **both** of the following occur:

- It is the calendar year *immediately* following the initial calendar year in which benefits are paid; and
- the patient is a covered person at the beginning of the year in which the restoration begins.

A maximum mental health restoration of **$20,000** is available for the lifetime of the patient.

AUTOMOBILE-RELATED INJURIES

The Traditional Plan will provide secondary coverage to Personal Injury Protection (PIP) unless the plan has been elected as primary coverage by or for the employee covered under this contract. This election is made by the named insured under the PIP program and affects that member's family members who are not themselves the named insured under another auto policy. The Traditional Plan may be primary for one member, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

The Traditional Plan is secondary to other automobile insurance coverage. However, if the other automobile insurance contains provisions which made it secondary or excess to the Traditional Plan, it will be primary.

If the Traditional Plan is primary to PIP or other automobile insurance coverage, benefits are paid in accordance with the terms, conditions and limits set forth in your contract and only for those services normally covered under the Traditional Plan.

Please note: If you elect to have the Traditional Plan as primary to PIP, prior notification to Horizon BCBSNJ is not required. Upon receipt of an auto related claim, Horizon BCBSNJ will request the submission of written documention, such as a copy of your policy declaration page, for verification of your selection.

If the Traditional Plan is one of several health insurance plans which provide benefits for automobile related injuries and the covered employee has elected health coverage as primary, these plans may coordinate benefits as they normally would in the absence of this provision.

If the Traditional Plan is secondary to PIP, the actual benefits payable will be the lesser of:

- the remaining uncovered **allowable expenses** after PIP has provided coverage, subject to contract medical appropriateness and other provisions, after application of deductibles and coinsurance; or
- the actual benefits that would have been payable had the Traditional Plan been providing coverage primary to PIP.

ELIGIBLE MAJOR MEDICAL SERVICES

SPECIFIC COVERAGE AREAS

In order to be eligible for reimbursement all services must be medically needed and meet all other plan provisions.

Acupuncture

Acupuncture treatment is covered when the services are for a diagnosis related to pain management and rendered by a Licensed Acupuncturist or Licensed Medical Doctor (MD, DO).

Examples of acupuncture services that are not eligible under the Traditional Plan include weight loss and smoking cessation.

Alcohol and Substance Abuse Treatment

Alcohol and **substance abuse** treatment is covered like any other illness. The following alcohol and substance abuse treatment services are covered when they are provided by an eligible **residential treatment facility** to a member who is being treated as an inpatient, outpatient, or when they are provided as aftercare by an eligible **detoxification facility**.

- Counseling for the family of the person who is receiving covered inpatient services, if the family member is covered under the contract.
- Initial evaluation.
- Individual and group therapy.

Allergy Testing

Most commonly used methods of allergy testing are covered. However, some methods are subject to medical necessity and appropriateness review before eligibility can be determined. This includes, but is not limited to, the following tests.

- RAST (Radioallergosorbent Testing).
- MAST (Multiple Radioallergosorbent Testing).
- FAST (Fluorescent Allergosorbent Testing).
- ELISA (Enzyme-Linked Immunosorbent Assay).

Ambulance

Ambulance use for local emergency transport to the nearest eligible facility equipped to treat the emergency condition is covered.

The Traditional Plan does not cover chartered air flights, non-emergency air ambulance, invalid coach, transportation services, or other travel or communication expenses of patients, practitioners, nurses, or family members.

Biofeedback

Biofeedback to treat a medical or biologically based mental illness diagnosis is covered like

any other general condition. Diagnoses that are considered non-biologically based psychiatric in nature will be subject to the mental health plan maximums under the Traditional Plan.

Breast Reconstruction

If you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, major medical will provide coverage for the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Prothesis(es).
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Physical complications at all stages of the mastectomy, including lymphedemas.

Chiropractic Services

Chiropractic services that are determined to be medically appropriate for the diagnosis or treatment of an illness or injury, acute condition, acute exacerbation of chronic conditions, and neuromuscular-skeletal conditions for which there will be some measurable improvement are considered for benefit reimbursement. In order to be considered, the treating chiropractor must be licensed, the services must be appropriate for the diagnosed condition(s), and the services must fall within the scope of practice of a chiropractor in the state in which he is licensed and practicing.

Chiropractic services that are determined to provide **maintenance** or **supportive care** are not covered. Maintenance care is defined as care given to reduce the incidence or prevalence of illness, impairment, and risk factors and to promote optimal function. Maintenance treatments are considered to be not medically needed and are therefore, not eligible for coverage. Frequently, treatment for a chronic condition, such as a bad back, reaches a plateau. That is treatment brings a member to a point when further treatment cannot be reasonably expected to improve the diagnosed condition. Instead it maintains the members' current condition. When such a point is reached, further treatment is deemed to be maintenance care and is no longer eligible for coverage. Supportive care is defined as treatment for patients having reached maximum therapeutic benefit in whom periodic trials of therapeutic withdrawals fail to sustain previous therapeutic gains that would otherwise progressively deteriorate. In some instances, chiropractic manipulation may be clinically appropriate (such as treatment of a chronic condition that requires supportive care) yet not eligible for reimbursement.

Chiropractic utilization will be monitored to identify potential case management opportunities through an ongoing analysis of the claim submission and history. When such cases are identified based on a retrospective review of the claims history, a letter will be sent to you and/or your provider requesting medical records. Any claims incurred subsequent to the date of this letter will require the submission of medical records and a formal treatment plan to establish medical appropriateness as defined by the plan. No additional chiropractic claims will be paid until the records are provided and the review is completed. If the services rendered after the date of the request for records are determined to be ineligible, you will be responsible for payment of all services incurred after the date of the letter notifying you that records have been requested.

All reviews of chiropractic treatment records will be performed by a licensed chiropractor.

Reviews will focus on the medical appropriateness of the services and/or whether the condition for which care is being rendered has reached a level of maximum therapeutic improvement where care may be considered maintenance. Should the patient seek chiropractic care for a new diagnosis or an exacerbation of an existing condition, medical records must be submitted for review. These records, in conjunction with the patient's prior chiropractic treatment history, will be reviewed by a licensed chiropractor. Submission of these documents is not a guarantee of payment.

Congenital Defects

Procedures necessary to correct congenital birth defects, which significantly impair function, including dental procedures, are covered.

Dental Care

Dental care under the Traditional Plan is very limited. The plan will pay a basic benefit for the removal of bony impacted molars, and will pay for the treatment of accidental injuries (see below), and treatment for mouth tumors if **medically necessary**. See page 23 for a discussion of Basic Benefits.

Extended basic coverage will pay for professional fees for covered dental services, including anesthesia, whether performed in a hospital or a dental office.

There is no additional coverage through major medical toward the removal of bony impacted molars and impacted bicuspids.

Accidental Dental

The major medical portion of the Traditional Plan may provide coverage for the treatment of accidental dental injuries. Accidental dental is considered an injury to teeth (must be sound natural teeth) which is caused by an external factor such as damage caused by being hit by a hockey puck or having teeth broken in a fall on the ice.

Breaking a tooth while chewing on food is not considered accidental dental. Examples of ineligible dental services include, but are not limited to, breaking a tooth on a popcorn seed, olive pit, or on a bone in a piece of meat.

Stress fractures in teeth are very common and undetectable by X-ray. Stress fractures are often the cause of tooth breakage. Treatment for this type of tooth breakage is considered dental services, and is not eligible for reimbursement.

The major medical portion of the Traditional Plan may also provide coverage for dental prostheses to replace accidentally injured teeth, if the treatment and replacement occur within 12 months of the accident. A treatment plan must be submitted. If it is determined that treatment cannot be reasonably completed within 12 months, this time limit may be extended.

Diabetic Self-Management Education

Diabetes self-management education is covered when the services are provided by one of the following:

- Physician
- Nurse practitioner

— Clinical nurse specialist
— Registered dietician certified as a diabetic educator
— Pharmacist
— Podiatrist

Eligible services for Traditional Plan members that have been diagnosed with diabetes include:

— One initial diabetic self-management session.
— A maximum of four follow-up refresher sessions per calendar year.

Infertility Treatment

The following State Health Benefits Program (SHBP) Assisted Reproductive Technology (ART) benefits were effective as of July 1, 2000, for members of the Traditional Plan, NJ PLUS, and Aetna US Healthcare.

[In Vitro Fertilization (IVF), Embryo Transfer (ET), Zygote Intrafallopian Transfer (ZIFT), Gamete Intrafallopian Transfer (GIFT)]

All services must be provided at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetrics and Gynecology.

Eligible services

— Consultations with infertility specialists and/or at comprehensive infertility centers are covered. Under the Traditional Plan and NJ PLUS out-of-network, screening tests such as HIV, routine PAP, hepatitis panels, etc., which may be required prior to infertility treatments will not be covered expenses. Under HMO and NJ PLUS in- network, those expenses will be covered.
— Ovulation Induction and Monitoring are covered.
— Laparoscopy, laparotomy, and hysteroscopy for diagnosis or treatment of infertility are covered.
— Attempts to reverse prior sterilizations are covered.
— Infertility treatment is covered if the member had a prior sterilization procedure.
— Up to six attempts at artificial insemination are covered when in concert with ovarian hyperstimulation or when using donor sperm. Artificial insemination is less invasive than other infertility procedures and significantly less expensive and should be attempted when it is likely to succeed.
— The SHBP limits the reimbursement of ART procedures (i.e., IVF[1], ZIFT[2], GIFT[3])

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[1]IVF is In Vitro Fertilization which is a four step procedure. 1) Eggs produced by administering fertility drugs (gonadotropins) are 2) retrieved from the woman's body and 3) fertilized by sperm in a laboratory dish. The resulting embryos are 4) transferred by catheter to the uterus.

[2]ZIFT is Zygote Intrafallopian Transfer in which eggs are fertilized by sperm in a laboratory dish and resulting embryos are transferred to the woman's fallopian tubes from which they travel naturally to the uterus.

[3]GIFT is Gamete Intrafallopian Transfer wherein, following hormonal stimulation of egg production, a mixture of sperm and eggs is transferred, using a minor surgical procedure, to the fallopian tubes, where fertilization may occur.

and related services to three attempts per successful pregnancy. *An attempt is recorded for IVF or ZIFT when egg harvesting or retrieval and either culture and fertilization of oocyte(s) or intracytoplasmic sperm injection (ICSI) is performed; or, with GIFT, when the gametes are actually transferred to the recipient's fallopian tube.* A successful pregnancy is defined as producing a live newborn. Embryo transfers using frozen embryos do not count as a separate IVF or ZIFT attempt. If the first three attempts are not successful, there is no further IVF, ET, ZIFT or GIFT benefit. This is a lifetime benefit maximum under the SHBP self-insured plans. In other words, before certifying benefits, the self-insured plans will have to ascertain whether previous attempts have been covered by any of the other self-insured plans in the SHBP.

Examples of some of the related services that would be covered within the three attempts include initial consultation, office visits, cost of the drug(s), laboratory and/or radiologic procedures, testicular sperm aspiration (TESA) and percutaneous epididymal sperm aspiration (PESA) and the process of cryopreservation of embryos[4] although not the storage costs. These procedures would all be subject to the member's deductible and coinsurance or copayment requirements and any lifetime major medical benefit maximum.

— In addition, any necessary ovum or sperm donor costs would be covered, including but not limited to office visits, costs of drugs, laboratory and/or radiologic procedures, retrieval, cryopreservation, etc. but not including costs for transportation, lodging, or any compensation.

— An attempt is recorded based on the criteria defined in number seven (above) regardless of whether fertilization or transfer is successful. This is also true whether or not the pregnancy goes to term, results in a live birth, or if it results in an ectopic pregnancy.

— The number of embryos to be transferred must follow standards set by the American Society of Reproductive Medicine.

— Fetal reductions are covered.

— Blastocyst transfer is covered.

— Assisted hatching techniques are covered, including, but not limited to partial zona dissection, laser zona dissection, zona pellucida or subzonal drilling.

— Microscopic assessment of oocyte(s), thawing and preparation of cryopreserved embryos, sperm identification from aspiration and preparation for transfer of embryos are covered services.

— The health plan may negotiate global fees for Assisted Reproductive Technology services and procedures with providers. Global fees would include office visits, would remain at the prevailing reimbursement rate (customary charge level), and would be based on an attempt basis. Where global fees cannot be negotiated, reasonable and customary fee allowances will be paid.

— The process of cryopreservation and sperm banking for a male undergoing can-

[4]Cryopreservation is freezing of embryos after a previous ART cycle for later thawing and transferal to the uterus without the need for repeat stimulation and retrieval during subsequent cycles.

cer treatment who may become infertile as a result are covered. Expenses for storage are not covered.

Ineligible services

— Services or procedures that are not eligible for separate or additional reimbursement since they are considered part of another more global service or procedure include, but are not limited to:

— Medical management fees, cycle management fees, administrative fees, and/or professional management fees billed in addition to office visits.

— Donor compensation fees

— Documentation of fertilization

— Mock transfers

— Uterine sounding

— The following services are considered investigational and therefore ineligible for benefit:[5]

- Acrosome reaction assay - a diagnostic tool that may be used in the evaluation of male infertility or sub-fertility. The acrosome (part of the sperm) is observed under a microscope for "reaction" after being subjected to a stimulus. Based on the reaction, it is proposed that poorly fertilizing sperms can be differentiated from those with good fertilizing capacity.
- Subzonal insemination (SUZI)
- Intratubal insemination

— The following are ineligible for benefit:

- Ovulation kits or sperm testing kits and supplies
- Donor search fees
- Cycle management fees or medical management fees
- Pre-implantation Genetic Diagnosis (PGD)
- Storage of frozen embryos or sperm
- Costs involving surrogate motherhood are not covered.
- Under the Traditional Plan and out-of-network in NJ PLUS, screening tests are not covered, including the PAP, HIV, hepatitis panels, etc. which are routinely required prior to IVF. These tests are covered under the HMO plans and in-network NJ PLUS.

Lithotripsy Centers

Lithotripsy services are covered when they are performed in an approved hospital or lithotripsy center. The approved centers in New Jersey are:

— Stone Center at UMDNJ - Newark.

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[5]This list is not all inclusive and does not include all investigational services and procedures. Denials are not limited to those on this list.

— Midlantic Stone Center - Marlton.

— NJ Kidney Treatment Center - New Brunswick.

Information regarding out-of-state approved lithotripsy centers may be obtained by calling the Horizon BCBSNJ Customer Service line at 1-800-414-SHBP (7427).

Lyme Disease Intravenous Antibiotic Therapy

All intravenous antibiotic therapy for the treatment of Lyme Disease must be pre-certified by Horizon BCBSNJ. When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

To pre-certify intravenous therapy for treatment of Lyme Disease, please call Horizon BCBSNJ's representative, CareAdvantage, at 1-800-624-1294.

Diagnosis

All testing should be initiated by antibody capture immunoassay, enzyme-linked immunosorbent assay (ELISA), or immunoflourescence assay (IFA) as "screening" tests. Because these tests are generally sensitive, specimens negative by ELISA or IFA need not be further tested since the diagnosis of Lyme disease can virtually be excluded. However, specimens that are positive, minimally reactive, or equivocal by ELISA or IFA should be confirmed by Western blots because of their relatively low specificity.[6] If early Lyme Disease is suspected clinically despite a negative antibody titer, serological investigations (starting with ELISA or IFA) should be repeated approximately 2 to 4 weeks later since 60 percent of infected individuals may test negative at the early stage. Antibiotic therapy may prevent an increase in specific antibodies and seroconversion may even occur after antibiotic therapy.

IgM Western blot is considered positive if two of the following three bands are present: 24 Da (OspC), 39 kDa (BmpA), and 41 kDa (Fla). IgG Western blot is considered positive if five of the following 10 bands are present: 18 kDa, 21 kDa (OspC), 28 kDa, 30 kDa, 39 kDa, 41 kDa (Fla), 45 kDa, 58 kDa (not GroEl), 66 kDa, and 93 kDa.

Serological findings are dependent on disease duration and clinical manifestation.

Early Localized Lyme Disease (Erythema migrans rash)

— With *early localized Lyme Disease*, less than half of patients have detectable specific antibodies, predominantly IgM. Serologic testing is unnecessary.

Covered Treatment: Early localized Lyme Disease should be treated with oral antibiotic therapy, preferably a 21-day course of doxycycline or amoxicillin, not intravenous therapy. [Patients intolerant to those oraal medications may be treated with cefuroxime axetil (oral), clarithromycin (oral), or azithromycin (oral).][7] Intravenous therapy is not appropriate unless oral medications are not tolerated. If intravenous antibiotic therapy must be used, 14 days of antibiotic therapy is

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[6]In the early stage of the disease (localized or even disseminated), there may be isolated IgM reactivity to ELISA or IFA, or in a minority of patients, there may only be an IgG response. Therefore, both IgM and IgG Western blots are recommended in the early stage.

[7]Note: cefuroxime axetil, clarithromycin, and azithromycin have been studied only in early, localized Lyme Disease, and azithromycin has been shown to be inferior to amoxicillin.

equivalent to 21 days of oral doxycycline.[8]

Early Disseminated Lyme Disease (Erythema migrans rash with multiple lesions, migratory joint pains and brief arthritis attacks, meningitis, cranial neuritis (usually facial palsy), carditis (usually AV nodal block))

— With early disseminated Lyme Disease, the proportion of detectable specific antibodies rises to 70-90 percent with a switch from IgM to IgG. In order to be considered medically appropriate, the following criteria must be met where applicable:

1) Medical certification of early disseminated disease (disseminated infection with cardiac and neurological problems),

2) Symptomatic pregnant women with failed course of oral antibiotics.

Covered Treatment:

- Early disseminated disease is treated with oral antibiotics (doxycycline 100 mg. twice a day or amoxicillin 500 mg. three times a day for 21 days).
- Facial palsy with meningitis: doxycycline 200 mg. twice a day or ceftriaxone 2 grams daily for 21 days or, if that is not tolerated, may treat with intravenous antibiotic therapy.
- Intravenous therapy is appropriate for Lyme Carditis or AV block with PR interval greater than 0.3 seconds, for children under the age of nine, or if patient is unable to tolerate oral antibiotics (nausea, vomiting, or malabsorption syndrome).
- Oral antibiotic therapy may be medically appropriate instead of intravenous therapy for palpitations in the absence of EKG changes; "funny feeling on one side of the face" in the absence of facial droop; facial palsy with normal cerebrospinal fluid results.

All intravenous therapy for treatment of Lyme Disease must be pre-certified by CareAdvantage (who provides this service for Horizon BCBSNJ). When intravenous therapy is determined to be medically appropriate, the supplies, cost of the drug, and skilled nursing visits will be covered services.

Pulse therapy, pulse treatment with Imipenem, therapy with Vancomycin, and diagnostic tests involving urine antigen and urine and serum polymerase chain reaction (PCR) are to be considered investigational.

Late/Chronic Disease Lyme Arthritis and Late/Chronic Disease Neuroborreliosis, (Persistant infection with prolonged arthritis attacks, chronic encephalomeyelitis, chronic axonal polyradiculopathy, acrodermatitis chronica atrophicans)

In order to be considered medically appropriate, the following criteria must be met where applicable:

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[8]"Ceftriaxone compared with doxycycline for the treatment of acute disseminated Lyme Disease". New England Journal of Medicine 1997. 337:289-94.

— Diagnosis based on objective findings including, but not limited to, serologic tests; spinal fluid analysis, neuropsychologic studies, and/or MRI.

— **Neuroborreliosis**, there is no role for IgM ELISA or Western Blot in late stage disease because the IgM tests have been shown to have a high number of false positives (low specificity) in patients whose symptoms have been present for more than one month. IgG Western Blot is usually sensitive and specific in this stage. IgG titers are usually high and may remain so for several years, even when treatment is successful. Elevated serum IgG alone indicates previous exposure to B. burgdorferi but not necessarily recent or active infection. In no case should serologic reactivity be considered synonymous with active infection.

— Spinal fluid analysis is mandatory in testing for neuroborreliosis unless a patient has a reactive serum test with a confirmatory IgG Western blot and signs of neurologic disease. If a patient has a clinical picture consistent with neuroborreliosis, spinal fluid analysis may be appropriate even in the absence of a positive serologic test. Intravenous antibiotic therapy will not be covered for possible neuroborreliosis in the absence of a reactive serologic test without performing further studies to confirm the diagnosis, i.e., CSF analysis and neuropsychological testing or SPECT scanning.[9]

— Expressing cerebrospinal fluid (CSF) and serum ELISA results as a ratio may help correct for passive diffusion of anti-Borrelia antibodies across the blood brain barrier and can also be used to support (but not confirm) a clinical diagnosis of neuroborreliosis. If the patient has cognitive dysfunction, neuropsychologic studies should be done. If there is peripheral nerve damage, EMG and nerve conduction velocity (NCV) studies are indicated: if there are sensory changes only, somatosensory evoked potentials (SSEP) are in order.

Covered Treatment: may be treated with up to 30 days of intravenous antibiotic therapy.

A second or extended course of intravenous therapy must be pre-certified by CareAdvantage (who provides this service for Horizon BCBSNJ). at its sole discretion prior to extending the course of therapy. There must be sufficient objective evidence, including objective clinical and laboratory findings, of new or extending manifestations of the disease. The plan administrator may require a consultation with an appropriate specialist.

Note: *Requests for more than 30 days require clinical/laboratory documentation of the need.*

A second course of intravenous therapy is warranted for any one of the following indications:

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[9]Single photon emission computed tomography (SPECT) scanning in and of itself is not suitable to establish the diagnosis of Lyme Disease. It is, however, useful to evaluate regional cerebral blood flow and is to be covered by the plan administrator for patients suspected of Late/Chronic Neuroborreliosis. SPECT scanning has been reported to show at six months that perfusion abnormalities improve in patients with Lyme encephalopathy after a one-month course of intravenous ceftriaxone. Therefore, it may be helpful to demonstrate whether a patient with suspected Lyme Disease actually has encephalopathy and may be helpful to follow response to therapy. SPECT scanning is not required in all patients and should only be used as an adjunct to other diagnostic tests when there is uncertainty as to the patient's diagnosis or response to therapy.

— clinical evidence of recurrent or new synovitis if other causes have been ruled out;

— clinical evidence of recurrent or new objective neurologic physical findings in the absence of other explanations;

— laboratory evidence of persistent (non-improving) CSF pleocytosis if other causes have been ruled out (if the spinal fluid showed a marked improvement but not complete resolution of the pleocytosis soon after completing therapy, another course of therapy may not be warranted);

— laboratory evidence of persistently positive CSF and/or synovial fluid culture, i.e., positive after initial intravenous treatment;

— laboratory evidence of positive Polymerase Chain Reaction[10] (PCR) in CSF[11] and/or synovial fluid - PCR urine or blood tests are not to be considered.

Extended intravenous therapy beyond 30 days as a second course may be approved only if there is:

— recurrent Lyme arthritis with active synovitis after a 30-day course of appropriate antibiotics (ceftriaxone, cefotaxime, penicillin G); or

— recurrent neuroborreliosis, documented by CSF pleocytosis, CSF culture, or PCR of CSF[12], or neuropsychological studies.

Examples of cases where an extension or repeat course of intravenous therapy may be medically appropriate include: a patient who had left knee arthritis and received treatment only to develop neurologic disease or arthritis of another joint after termination of treatment; a patient who had treatment of established Lyme Disease in the past and now develops new findings with increasing reactivity with Borrelia Burgdorferi as indicated by expansion of the immunologic reactivity with new bands on Western blot.

Mammography Benefit

Coverage of screening mammographies is an exception to the general rule that well care is not covered under the Traditional Plan. Routine mammography is covered as follows:

— One baseline mammography at any age.

— Age forty and older, one screening mammography per year.

Mental Health Treatment

Mental health treatment by any of the following providers working within the scope of their licenses is covered if the treatment is determined to be medically needed and the patient has not reached the annual or lifetime benefit maximums:

— Licensed psychologist

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[10]PCR testing of CSF and synovial fluid are to be covered by the plan administrator for patients suspected of Late/Chronic Lyme Disease. Coverage for PCR testing for other uses or fluids will be determined by the plan administrator.

[11]A persistently positive PCR in spinal fluid should be interpreted with caution. It's not really known what it means. In conjunction with other clinical/laboratory data, it may help support the need for a second course of antibiotics. In and of itself, it would not mandate therapy.

[12]It would be reasonable to extend or repeat treatment if a patient had a persistently positive CSF PCR and ongoing symptoms.

— Medical doctor
— Licensed clinical social worker (L.C.S.W)
— Certified nurse practitioner (CNP)
— Clinical nurse specialist (CNS)

Services rendered for the treatment of a **biologically based mental illness** are treated like any other illness and are not subject to the 20-day maximum. Biologically-based mental illness includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Orthopedic shoes

Orthopedic shoes that are attached to a brace are covered. All other orthopedic shoes are not eligible for reimbursement.

Patient Controlled Analgesia (PCA)

Patient Controlled Analgesia (PCA) is covered when it is prescribed by a medical doctor and provided under the guidance of one of the following:

— Doctor
— Anesthesiologist
— Approved home care agency

Physical Therapy

Medically eligible physical therapy, that is not determined to be maintenance treatment, is covered based on one session per day. A session of physical therapy is defined as up to one hour of physical therapy (treatment and/or evaluation) or up to three physical therapy modalities provided on any given day.

Private Duty Nursing

Private duty professional nursing is only available under very strict standards. Private duty nursing will only be covered under extraordinary circumstances upon evidence of a clear and convincing objective need.

Private duty nursing must be ordered by a doctor; and provided by one of the following:

— Registered nurse (R.N.), other than you, your spouse, or a child, brother, sister, or parent of you or your spouse.
— Licensed practical nurse (L.P.N.), other than you, your spouse, or a child, brother, sister, or parent of you or your spouse.

Private duty nursing will not be covered if the care is:

— the type of care normally provided by or that should be provided by hospital nursing staff;
— rendered by or could be provided by home health aides or any other nurses' aides; or

— **custodial care** or assistance in the **activities of daily living** in a home or facility of any kind.

Scalp Hair Prostheses

A benefit maximum of $500 in a 24 month period, per person, is covered for scalp hair prostheses prescribed or authorized by a doctor, only if they are furnished in connection with hair loss resulting from:

— treatment of disease by radiation or chemicals;

— alopecia universalis (totalis); or

— alopecia areata.

Second Opinion Consulting Services

The major medical portion of the Traditional Plan provides coverage for a second physician's personal examination of a patient following a recommendation for any eligible surgical procedures. The plan will pay for one consultation by a qualified specialist physician.

If the second opinion specialist does not confirm the need for surgery, the major medical portion of the Traditional Plan will provide coverage for one additional consultation if requested by the patient. The plan also will provide coverage for any diagnostic X-rays, laboratory tests, or diagnostic **surgical procedures** required by the physicians performing the consultations. Coverage for these diagnostic services will be provided even if these services would not otherwise be eligible under the Traditional Plan.

If the second surgical opinion is arranged through Horizon BCBSNJ's representative, CareAdvantage at 1-800-624-1294, and a **participating provider** is utilized, there is no member liability. Otherwise, **deductible** and **coinsurance** amounts will apply.

Shock Therapy Benefits

Basic (first-dollar) benefits are payable for charges for electroshock treatments, insular shock treatments, and other similar treatments given for mental, psychoneurotic, or personality disorder and then major medical benefits apply. Benefits are also payable for anesthesia in connection with the shock treatment and for all other eligible services performed on that day for the disorder. There is a limit of 12 shock treatments in each calendar year for each eligible person.

Speech Therapy Benefit

Speech therapy services provided by a qualified speech therapist are covered as follows.

— Speech therapy services to restore speech after a loss of a demonstrated previous ability to speak or impairment of a demonstrated previous ability to speak. The loss or impairment cannot be caused by a mental, psychoneurotic, or personality disorder.

— Speech therapy to develop or improve speech after surgery to correct a defect that existed at birth and impaired the ability to speak, or would have impaired the ability to speak.

In addition, speech therapy services will be considered eligible for a period of one year for children with a documented medical history of multiple cases of

Otitis Media and one or more myringotomy(ies).

Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed is not covered under the Traditional Plan.

Surgical Services

— **Multiple Procedures**

If multiple procedures are performed during the same operative session, the procedure with the highest charge will be considered the primary procedure and the full **reasonable and customary (R&C) fee** will be allowed for that primary procedure minus any applicable **deductible** and **coinsurance** liability. All additional procedures performed in the same operative session will be paid at 50 percent of the R&C fee.

— **Bilateral Procedures**

Bilateral procedures will be paid at 150 percent of the R&C fee for one procedure. Services qualify as bilateral when anatomically there are two specific body parts such as ears, eyes, knees, breasts, and kidneys. A lesion on the right arm and a lesion on the left arm would not qualify as bilateral since the skin is one body organ.

Temporomandibular Joint Disorder (TMJ) and Mouth Conditions

Medical and surgical services performed for the treatment of the jaw are covered. Services in relation to the teeth in any manner are excluded. Charges for doctor's services or X-ray examinations for a mouth condition are not eligible.

Charges for dental or orthodontic services for a TMJ diagnosis are not eligible. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of TMJ or malocclusion involving joints or muscles by methods including but not limited to crowning, wiring, or repositioning of teeth and dental implants.

Voluntary Case Management

The State Health Benefits Program provides voluntary case management services to Traditional Plan members. It is often more cost effective and convenient for a **case manager** to be involved in the coordination of care for a critically/catastrophically ill member in some situations. This service is purely voluntary. You do not have to take advantage of it.

By utilizing the services of a case manager, your medically appropriate care is coordinated and managed to provide the most cost-effective approach for the completion of long-term care goals.

For the patient's family, the primary advantage of case management is the additional flexibility and support provided by the case manager. Sometimes it is possible for the patient to be treated at home or in an alternate setting, such as a rehabilitation center or hospice, with additional services or home health assistance.

Some conditions that typically benefit from the services of a case manager are as follows:

— Severe head injuries.

- Spinal cord injuries.
- Severe burn effecting 20 percent or more of the body area.
- Multiple injuries due to an accident.
- Premature birth.
- CVA or stroke.
- Congenital defect which severely impairs a bodily function.
- Brain injury or defect caused by an accident or other unforeseen incident.
- Terminal illness in which a physician has confirmed a life expectancy of 6 months or less.
- AIDS.

Services that would be considered for case management are identified in various ways.

- Hospital discharge planners contact Horizon BCBSNJ.
- Claim submissions indicate a diagnosis that may benefit from case management services.
- Direct contact by a member or family member inquiring about available case management services.

While the claims administrator may suggest that case management is appropriate for a particular case, the claims administrator is not responsible for initiating case management. Once it has been agreed that the patient can benefit from case management services, the case manager and the patient's physician will plan a course of treatment to provide the most efficient and cost effective quality care possible.

If you would like more information about Voluntary Case Management, please call 1-800-624-1294.

Charges Not Covered By The Plan

— Automobile accident-related injuries or conditions. The Traditional Plan does not pay for the treatment of injuries or conditions related to an automobile accident if automobile insurance could have or should have covered the treatment. This exclusion applies to, but is not limited to:
  - existing motor vehicle insurance contracts;
  - motor vehicle contracts that were purchased but have since lapsed;
  - motor vehicle insurance coverage that should have been purchased; and
  - failure to make timely claims under a motor vehicle insurance policy.

— Autopsy.

— Care that is primarily custodial in nature.

— Chair and stair lifts.

— Charges above the reasonable and customary fee.

— Charges for services or supplies not specifically covered under the plan.

— Charges that should have been paid by Medicare, if Medicare coverage had been in effect.

— Charges incurred prior to legal adoption.

— Charges for the completion of a claim form, photocopies of pertinent medical information, or medical records.

— Cosmetic procedures - charges connected with curing a condition by cosmetic procedures. This provision does not apply if the condition is due to an accidental injury that occurred while the injured person is enrolled in the plan. Among the services that are not covered are:
  - removal of warts and other abnormal skin growths with the exception of plantar warts;
  - varicose vein treatment; and
  - plastic surgery when performed primarily to improve the person's appearance.

— Costs involving surrogate motherhood.

— Court ordered services or treatments.

— Custom-molded shoes.

— **Durable medical equipment** or supplies which are specifically excluded from coverage. To determine coverage for equipment or supplies, call 1-800-414-SHBP.

— Educational or developmental services or supplies. This includes services or supplies that are rendered with the primary purpose being to provide the person with any of the following:
  - Training in the **activities of daily living.** This does not include training directly related to treatment of an illness or injury that resulted in a loss

of a previously demonstrated ability to perform those activities.

- Instruction in scholastic skills such as reading and writing.
- Preparation for an occupation.
- Treatment for learning disabilities.
- To promote development beyond any level of function previously demonstrated.

In the case of a hospital stay, the length of the stay and hospital services and supplies are not covered to the extent that they are determined to be allocated to the scholastic education or vocational training of the patient.

— Experimental or investigational services or supplies and charges in connection with such services or supplies (see page 17).

— Eye care including:

- Examinations to determine the need for glasses or lenses of any type, typically known as refraction examinations regardless of the diagnosis.
- Eyeglasses or lenses of any type except initial replacement for loss of the natural lens after cataract surgery.
- Low vision aids.
- Eye surgery, such as radial keratotomy, or lasik procedures to correct myopia (Nearsightedness), hyperopia (far sightedness), or astigmatism (blurring) whether performed for cosmetic or work-related purposes.

— Foot conditions - charges for doctor's services for:

- A weak, strained, flat, unstable or imbalanced foot, metatarsalgia or a bunion. However, this exclusion does not apply to an open cutting operation.
- One or more corns, calluses, or toenails. This exclusion does not apply to a charge for the removal of part or all of a nail root and services connected with treating metabolic or peripheral vascular disease.

— Government plan charge including a charge for a service or supplies:

- furnished by or for the United States government;
- furnished by or for any government, unless payment is required by law; or
- to the extent that the service or supply, or any benefit for the charge, is provided by any law or government plan under which the member is or could be covered. This applies to Medicare and "no-fault" medical and dental coverage when required in contracts by a motor vehicle law or similar law.

— Hearing Aids.

— Hearing examinations to determine the need for hearing aids or the need to adjust a hearing aid, no matter what the cause of the hearing loss.

— Herbal or alternative medicine treatments.

— Hypnosis.

— Immunizations and preventive vaccines.

— **Maintenance** or **supportive care**. Frequently, treatment (ie: chiropractic care and physical therapy) for a chronic condition, such as a bad back, reaches a plateau. That is, treatment brings a member to a point when further treatment cannot be reasonably expected to improve the diagnosed condition. Instead it maintains the member's current condition. When such a point is reached, further treatment is deemed to be maintenance care and is no longer eligible for coverage.

— Modifications to an auto to make it accessible and/or driveable.

— Modifications to a home to make it accessible for a disabled person.

— Mouth conditions - charges for doctor's services or X-ray examinations for a mouth condition. This exclusion applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint disorders (TMJ) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring, or repositioning of teeth. See page 74 in the Glossary for definition of a **mouth condition**.

— Nursing home care.

— Over-the-counter supplies, supplements, vitamins, medications or drugs that do not require a prescription order under Federal law, even if the prescription is written by a physician. These include, but are not limited to, aspirin, vitamins, lotions, creams, oils, formulas, liquid diets, and dietary supplements.

— Personal comfort or convenience items including telephone or television service, haircuts, guest trays, or a private room during an inpatient stay.

— Private rooms in a hospital. If you occupy a private room in a hospital or facility, you must pay the difference between the private room rate and the average semiprivate room rate.

— Preventive care/routine screening services. - Unless otherwise indicated, the Traditional Plan does not provide coverage for services or supplies that are considered to be performed for any of the following:

  - Routine well-care as part of a routine examination.
  - Services and supplies that are provided for a diagnosis that does not indicate an illness present at the time the service are rendered.
  - Services that are considered preventive or screening in nature.

  For example:

  - A Pap smear that is part of a routine annual gynecological examination or recommended due to a family history of disease.
  - Cancer antigen tests (CA125, CA27-29, Prostate Specific Antigen or PSA, etc.) as part of a routine examination or recommended due to a family history of disease. Specific guidelines apply to the eligibility of cancer antigen tests for non-routine reasons. Therefore, you may wish to request a pre-determination of benefits prior to having services rendered.

- All immunizations/vaccinations.
- Flu shots/pneumonia vaccines.
- Well-child vaccinations/immunizations.
- Well-care annual physicals.

— For members covered by Medicare, services rendered by providers who do not participate with Medicare.

— Services involving equipment or facilities used when the purchase, rental, or construction of them has not been approved in compliance with applicable state and federal laws and regulations.

— Services or supplies that are not medically needed or not appropriately provided and charges in connection with such services or supplies. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and diagnosis of an illness or injury or make it a covered medical expense.

— Services that are commonly or customarily provided without charge to the patient. Even when the services are billed, the plan will not pay if they are usually not billed when there is no coverage available.

— Services and supplies prescribed or provided by an ineligible provider.

— Services rendered before the effective date of coverage or after the termination of coverage date. However, if the covered patient is hospitalized as an inpatient and coverage terminates during the stay, that inpatient stay (as long as otherwise eligible) will be covered through to discharge.

— Speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed.

— **Supportive care** - Frequently, treatment (ie: chiropractic care and physical therapy) for a chronic condition, such as a bad back, reaches a plateau. That is, treatment brings a member to a point when further treatment cannot be reasonably expected to improve the diagnosed condition. Instead it maintains the member's current condition. When such a point is reached, further treatment is deemed to be **maintenance care** and is no longer eligible for coverage.

— Transport - Non-emergency transport via ambulance or transport by coach of any kind (on land, air or water).

— War - charges for illness or injury due to a current act of war. War means either declared or undeclared, including resistance or armed aggression.

— Work-related injury or disease. This includes the following:

- Injuries arising out of or in the course of work for wage or profit, whether or not you are covered by a Workers' Compensation policy.
- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
- Work-related tests, examinations, or immunizations of any kind required by your work

  Please note: If you collect benefits for the same injury or disease from

both Workers' Compensation and the State Health Benefits Program, you may be subject to prosecution for insurance fraud.

Examples of Non-Covered Services:

Example 1: A physician orders inpatient private duty nursing for a surgery patient. Since private duty nursing is not covered under the plan while confined in a hospital, because these nursing services are provided by the hospital, the charges for private duty nursing will not be paid.

Example 2: A person is studying to become a therapist and is required by the school to enter therapy. The treatment is intended to ensure that the new therapist is well-equipped to work with patients. The treatment is not covered because it is primarily educational.

Example 3: A physician orders a drug that is FDA-approved but is not commonly used to treat the particular condition. If the plan determines that the use is so new it is experimental; the plan will not pay for the drug.

Example 4: A hospital routinely requires an assistant to be present at certain operations. Other hospitals do not have that requirement. The plan will not pay for the assistant unless it can be demonstrated that the service was medically necessary.

THIRD PARTY LIABILITY (SUBROGATION)

If you or your dependents incur medical expenses as a result of the actions of a third party (anyone other than you or the Traditional Plan) and the plan has made payment for those expenses, the plan has the right to recover those payments.

This means if your medical expenses are reimbursed by a third party, satisfied judgment or other means, you are required to return any benefits paid for an **illness, accidental injury,** or **mental or nervous condition** or **substance abuse** to the Traditional Plan.

Repayment Agreement

If you file a claim with the Traditional Plan and Horizon BCBSNJ suspects that you may be receiving payment from a third party, you must agree in writing to repay SHBP.

The repayment will only be equal to the amount paid by us. However, you may deduct any reasonable costs, such as lawyers' fees or court costs incurred in obtaining the third party payment.

This repayment agreement will be binding whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or whether the Third Party has admitted liability for the payment.

Recovery Right

If you have received benefits from the Traditional Plan as a result of the actions of a third party, the plan may:

- assume your right to receive payment for benefits from the third party;
- require you to provide all information and sign and return all documents necessary to exercise the Traditional Plan's rights under this provision, before any benefits are provided under your group's policy; or
- require you to give testimony, answer interrogatories, attend depositions, and comply with all legal actions which the Traditional Plan may find necessary to recover money from all sources when a third party may be responsible for damages or injuries.

The Traditional Plan will not provide any benefits to you if you have received payment in whole or in part from a third party or its insurer for past or future charges for an **illness, accidental injury, mental or nervous condition**, or **substance abuse** resulting from the negligence, intentional act, or no-fault tort liability of a third party.

WHEN YOU HAVE A CLAIM

FILING A CLAIM

Filing Deadline - Proof of Loss

Horizon BCBSNJ must be given written proof of a loss for which a claim is made under the coverage. This proof must cover the occurrence, character, and extent of the loss. It must be furnished **within one year and 90 days of the end of the calendar year in which the services were incurred.** For example, if a service were incurred in the year 2000, you would have until March 31, 2002, to file the claim.

A claim will not be considered valid unless proof is furnished within the above time limit. If it is not possible for you to provide proof within the time limit, the claim may be considered valid upon **appeal** if the reason the proof was not provided in a timely basis was reasonable.

Itemized Bills are Necessary

You must obtain itemized bills from the providers of services for all medical expenses. The itemized bills must include the following:

- Name and address of provider.
- Provider's tax identification number.
- Name of patient.
- Date of service.
- Diagnosis.
- Type of service.
- CPT 4 code.
- Charge for each service.

Foreign Claims

Bills for services that are incurred outside of the United States should include an English translation and the charge for each service performed. The exchange rate at the time of service should also be indicated on the bill that is submitted for coverage.

Filling Out the Claim Form

Be sure to fill out the claim form completely. Include the identification number that appears on your identification card. Fill out all applicable portions of the claim form and sign it. A separate claim form must be submitted for each individual and each time you file a claim. The claim mailing address, which is noted on the back of the claim form, is as follows:

New Jersey State Health Benefits Program
Horizon Blue Cross and Blue Shield of New Jersey
PO Box 1609
Newark, New Jersey 07101-1609

SUBMITTING A CLAIM

Hospital Claims

All New Jersey hospitals file claims directly with Horizon BCBSNJ. Out-of-state hospitals that participate with the local BCBS plan will file the claim for you through the **Blue Card Program**. If you have services out-of-state at a non Blue Card hospital or out of the country, you are responsible for submitting an itemized bill and a completed claim form to Horizon BCBSNJ.

Medical Claims

Providers in the **Participating Provider** network will file claims directly with Horizon BCBSNJ. Out-of-state providers that participate in the local BCBS plan will file medical claims Horizon BCBSNJ through the **Blue Card Program**. Many other providers will also file medical claims as a service to their patients. If they do not, you are responsible for submitting an itemized bill and a completed claim form to Horizon BCBSNJ.

Medicare Claims and Other Coverage

If a member is a New Jersey resident, has Medicare primary coverage and receives care within New Jersey, claims will be transmitted automatically from the Medicare carrier to Horizon BCBSNJ.

If a member resides in another state and has Medicare primary coverage, the member will have to submit a copy of the Medicare Explanation of Benefits (MEOB) along with a copy of the itemized bill and a completed claim form to Horizon BCBSNJ.

If the member has primary coverage with another carrier, the member must include a copy of the Explanation of Benefits (EOB) from the other carrier, an itemized bill, and a completed claim form.

Out-of-State Claims

Horizon Blue Cross Blue Shield of NJ participates in a program that uses nationwide contracting provider arrangements with all Blue Cross Blue Shield plans. This program allows SHBP participants the use of out-of-state hospitals and doctors. Participants of the SHBP may utilize the services of all hospitals and doctors across the nation who contract with independent Blue Cross Blue Shield Plans.

Authorization to Pay Provider

The medical expense coverage provided by the Traditional Plan is not assignable. However, the member (or a qualified dependent in case of the member's death) can, with the agreement of Horizon BCBSNJ, request that payment of any benefit for **eligible charges** payable to the member, instead be paid directly to the provider of service or supplies. Once payment is made to the provider at the member's request, Horizon BCBSNJ will not have to pay the benefit again. This direct payment is done as a courtesy to our member and is not an assignment of benefits. In order for benefits to be payable directly to a non-participating provider, the member must authorize this direction of payment by completing the appropriate section of the claim form.

The Providers that participate with any BCBS plan will be paid directly for eligible services.

QUESTIONS ABOUT CLAIMS

If you have questions about a hospital claim, hospital benefits, a medical claim, medical benefits, or if you need a claim form, call 1-800-414-SHBP (7427).

If for any reason the claim is not eligible, you will be notified of its ineligibility within 90 days of receipt of your claim. To request a review of the claim, you should follow the instructions described in the "Claims Appeal" section (page 14).

APPENDIX I

SUMMARY SCHEDULE OF SERVICES AND SUPPLIES

New Jersey statutes, administrative code, and agreements between the SHBP and Horizon BCBSNJ govern this plan. The following schedule of benefits is a summary description of plan benefits. It is not complete and does not describe all the limitations or conditions associated with the coverage as described in prior sections. All pertinent parts of this handbook should be consulted regarding a specific benefit. Health decisions should not be made on the basis of the information provided in this schedule.

This section lists the types of charges Horizon BCBSNJ will pay for covered services or supplies according to all provisions, including but not limited to medical necessity and medical appropriateness, the Schedule of Covered Services and Supplies, benefit limitations, and plan exclusions.

Please note: The fact that a doctor may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically needed for the treatment and/or diagnosis of an illness or injury or make it a covered medical expense.

The plan will provide the coverage listed in this Schedule of Covered Services and Supplies, subject to the terms, conditions, limitations and exclusions stated within this booklet.

Refer to the section of this booklet called "Charges Not Covered Under the Plan" to see what services and supplies are not covered.

BASIC (HOSPITALIZATION) BENEFITS

Benefit Period	**365** Days of Inpatient care per Benefit Period. Every two days in a member **skilled nursing facility** or every three home care visits will count as one benefit day for inpatient care. **365** Days of Outpatient care per Benefit Period.
Renewal Interval	Benefit Period is renewed when 90 days without care as an Inpatient in a Hospital have elapsed.

Covered Services

Inpatient Hospital Services	**100 percent** up to 365 day for semi-private room. Day 366+ subject to deductible and 20 percent coinsurance.
Skilled Nursing Facility Charges	**100 percent** for up to 30 days.

Ambulatory Surgical Center . . . . . **100 percent** for facility charges.

Home Health Agency Care . . . . . **100 percent** for up to 60 visits within 61 days, per occurence.

Hospice Care . . . . . **100 percent**.

Accidental Injury . . . . . **100 percent** for facility charges.

Inpatient Alcohol and Substance Abuse . . . . **100 percent**, same as general inpatient benefit.

Inpatient Mental or Nervous Conditions . . . . . **100 percent** for up to 20 Inpatient Days per calendar year. Expenses beyond 20 days are paid under major medical subject to annual and lifetime maximums, deductible and coinsurance. (For biologically based mental illnesses, coverage is the same as any other medical condition.)

Pre-admission Testing . . . . . **100 percent.**

Organ Transplants . . . . . **100 percent** for organ transplants at an approved participating facility. Non- participating facilities are covered at 80 percent subject to deductible and coinsurance. Prior authorization is required except for cornea and kidney transplants.

EXTENDED BASIC (MEDICAL-SURGICAL) BENEFITS

Covered Services

Unless otherwise noted, balance remaining after payment under Extended Basic benefits will be paid under the major medical portion of the Traditional Plan.

Bony Impacted Molars and Bicuspids . . . . . . Subject to **$264** per Benefit Period maximum for the removal (**$105** for the first tooth and **$53** for each of the next three teeth)

Please note: The remaining charge is the member's responsibility if there is no dental insurance coverage available; it is not eligible for benefit under the major medical coverage.

Chemotherapy . . . . . Subject to **$500** per Benefit Period maximum.

Newborn Well-Care . . . . . Subject to **$42** per Benefit Period maximum while both mother and child are hos-

	pitalized. **Please note:** The remaining charge is the member's responsibility; it is not eligible under major medical coverage.
Pathology	Subject to **$25** per Benefit Period maximum.
Physical Therapy	Subject to a **$50** per Benefit Period maximum.
Physician Services for Surgical Procedures	Subject to per Benefit Period maximums for specific surgical procedures.
Examples:	
Cesarean Section	Subject to a **$651** Benefit Period maximum.
Vaginal Delivery	Subject to a **$420** Benefit Period maximum.
Total Hysterectomy	Subject to a **$578** Benefit Period maximum.
D&C	Subject to a **$126** Benefit Period maximum.
Appendectomy	Subject to a **$368** Benefit Period maximum.
Repair Inguinal Hernia	Subject to a **$315** Benefit Period maximum.
Radioactive Isotope Studies	Subject to a **$125** Benefit Period maximum.
Radioactive Isotope Therapy	Subject to a **$500** Benefit Period maximum.
Radium, Radioactive Isotope (sealed sources) or Radon Therapy	Subject to a **$150** Benefit Period maximum.
Shock Therapy	Subject to a **12** Shock Treatment Benefit Period up to a fixed schedule amount.
X-rays (diagnostic)	Subject to a **$125** Benefit Period maximum.
X-ray Therapy	**$500** Benefit Period maximium for X-ray therapy performed outside a hospital.

MAJOR MEDICAL BENEFITS

Coinsurance	**20 percent** of Covered Charges.
Out-of-Pocket Maximum	After $2,000 in claims for each member, the Plan pays **100 percent** of covered services.

Note: The Out-of-Pocket Maximum cannot be met with:

- Non-covered charges.
- Deductibles.

- Co-payments.
- Expenses above the reasonable and customary fee (R&C).

Annual Deductible (see page 35) . . . . . **$100**/covered Person.

$200/Member and Spouse, Parent and Child, or Family.

Common Accident Deductible — If two or more covered persons in the same family are injured in the same accident, only one deductible will be applied in a benefit period to the covered services and supplies resulting from the accident.

Fourth Quarter Deductible Carry-over — Covered services and supplies incurred within the last 3 months of a benefit beriod which were applied against the deductible but did not satisfy the deductible may be carried over and applied against the deductible for the following benefit period.

Prior Carrier Deductible Carry-over — Charges for covered services and supplies which satisfied any portion of a deductible required for the final benefit period under the employer's prior major medical group contract will be applied to satisfy all or any portion of the initial deductible required under this program.

Major Medical Lifetime Maximum — One million dollars per covered person with an automatic limited restoration feature. At the start of each benefit period, any of the covered person's previously used part of a maximum will then be restored for future charges up to the lesser of (a) $2,000 or (b) the amount needed to restore the full maximum. If the covered person's coverage ends under the Traditional Plan and begins again at a later date, the lifetime maximum benefit resumes at the same level it was when the coverage ended.

Covered Services

(Subject to all plan provisions)

Acupuncture . . . . . Subject to deductible and **20 percent** coinsurance.

Allergy Testing and Treatment . . . . . Subject to deductible and **20 percent** coinsurance.

Ambulance Services . . . . . . Subject to deductible and **20 percent** coinsurance.

Alcohol and Substance Abuse Benefits . . . . . Subject to deductible and **20 percent** coinsurance.

Anesthesia . . . . . Subject to deductible and **20 percent** coinsurance.

Biofeedback for general conditions . . . . . Subject to deductible and **20 percent** coinsurance.

Biofeedback for mental diagnosis . . . . . Subject to deductible and **20 percent** coin-

	surance. Lifetime mental maximums apply. (For **biologically based mental illnesses**, coverage is the same as any other medical condition.)
Chiropractic Services	Subject to deductible and **20 percent** coinsurance.
Congential Defects	Subject to deductible and **20 percent** coinsurance.
Diabetes Benefits	Subject to deductible and **20 percent** coinsurance.
Durable Medical Equipment	Subject to deductible and **20 percent** coinsurance.
Mammography	Subject to deductible and **20 percent** coinsurance. Subject to a benefit maximum of one baseline at any age; for women age 40 and up, one per benefit period.
Mental or Nervous Conditions	Subject to deductible and **20 percent** coinsurance. Lifetime mental maximums apply. (For **biologically based mental illnesses**, coverage is the same as any other medical condition.)
Physical Therapy	Subject to deductible and **20 percent** coinsurance.
Private Duty Nursing	Subject to deductible and **20 percent** coinsurance.
Scalp Hair Prostheses	Subject to deductible and **20 percent** coinsurance. Subject to a 24 month period Maximum of **$500**.
Speech Therapy	Subject to deductible and **20 percent** coinsurance.

APPENDIX II

GLOSSARY

Accidental Injury — physical harm or damage done to a person as a result of a chance or unexpected occurrence.

Active Group Member — an employee who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage in the SHBP for him or herself and, if applicable, any eligible dependents. Also includes eligible employees or dependents who continue SHBP coverage as a subscriber in the SHBP's COBRA program.

Activities of Daily Living — day-to-day activities, such as dressing, feeding, toileting, transferring, ambulating, meal preparation, and laundry functions.

Allowable Expense — Charges for services rendered or supplies furnished by a health care provider that would qualify as a covered expense.

Ambulatory Surgical Center — an accredited ambulatory care facility licensed as such by the state in which it operates to provide same-day surgical services.

Appeal — a request made by a member, doctor, or facility that a carrier review a decision concerning a claim. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of need or appropriateness of treatment or whether treatment is considered experimental or educational in nature. Appeals to the Health Benefits Commission may only be filed by a member or the member's legal representative.

Basic Benefits — that portion of the Traditional Plan that provides coverage for eligible hospital (facility) charges. Basic benefits are paid according to a "first-dollar" basis either in full or at a specific fee schedule. Also known as hospitalization benefits.

Benefit Period — the twelve-month period starting on January 1st and ending on December 31st. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on your coverage date. The last Benefit Period ends when you are no longer covered.

Biologically Based Mental Illness — Diagnosed conditions including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Blue Card Program — a national Blue Cross and Blue Shield (BCBS) electronic claims billing program through which participating hospitals and doctors can transmit bills for BCBS plan members to any BCBS-administered health insurance program.

Calendar Year — a year starting January 1 and ending on December 31.

Case Manager — a person or entity designated by Horizon BCBSNJ to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment for

those members taking advantage of the Voluntary Case Management Program.

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law requires private employers with more than 20 employees and all public employers to allow covered employees and their dependents to remain on group insurance plans for limited time periods at their own expense under certain conditions.

Coinsurance — the portion of the eligible charge which is the member's financial responsibility.

Coordination of Benefits — the practice of correlating the payments a plan makes with payments provided by other insurance covering the same charges or expenses, so that (1) the plan with primary responsibility pays first, (2) reimbursement does not exceed 100 percent of the actual expense, and (3) the plan does not pay more than it would if no other insurance existed.

Cosmetic Services — services rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons.

Covered Person — an employee, retiree or COBRA participant or a dependent of an employee, retiree or COBRA participant who is enrolled in the Traditional Plan.

Coverage — the plan design of payment for medical expenses under the program.

Custodial Care — services that do not require the skill level of a nurse for performance. These services include but are not limited to assisting with activities of daily living, meal preparation, ambulation, cleaning and laundry functions.

Deductible — the portion of the first eligible charges submitted for payment in each calendar year that the major medical portion of the Traditional Plan requires the member or covered dependent to pay.

Dependent's Coverage — coverage of an eligible family member of an enrolled member.

Detoxification Facility — a health care facility licensed by the state it is in as a detoxification facility for the treatment of alcoholism and/or substance abuse.

Durable Medical Equipment — equipment, which is designed and able to withstand repeated use and is customarily, used to serve a member with a medical condition.

Eligible Charges — these are the charges that may be used as the basis for a claim. They are the charges for certain services and supplies to the extent the charges meet the terms as outlined below:

- Medically needed and appropriate treatment for the medical condition.
- Listed in covered services and supplies.
- Ordered by a doctor (as defined by the plan) for treatment of illness or injury.
- Not specifically excluded (listed in the "Charges Not Covered by the Plan" section).

— Provided while you or your eligible family members were covered by the plan.

For example:

Example 1: If your coverage ended on August 31 and you were treated by a doctor for a broken leg on August 30, the doctor's bill is eligible even if you do not send it to Horizon BCBSNJ until some time after August 30.

Example 2: If your coverage ended on August 31 and you were treated on September 1, the bill would not be eligible because you were not a member of the plan at the time the treatment was rendered.

Eligible Dependent — a member's spouse and unmarried child(ren) under the age of 23 who lives with and is substantially dependent upon the member for support. Children include natural, adopted, foster, and stepchildren. If a child is not capable of self-support when (s)he reaches age 23 due to mental illness, mental retardation, or a physical disability, coverage under the SHBP may be continued (see page 1).

Emergency — A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or a guardian of a disabled individual), who posesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

— Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

— Serious impairment to bodily function.

— Serious dysfunction of bodily organ or part.

Claims will be paid for emergency services furnished in a hospital emergency department if the presenting symptoms reasonably suggested an emergency condition as would be interpreted by a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency condition will be covered.

Employer — The State, or a local public employer which participates in the State Health Benefits Program.

Extended Basic Benefits — that portion of the Traditional Plan that provides coverage for eligible medical-surgical (professional) charges such as X-rays and lab tests and surgical expenses. Extended basic benefits are paid on a "first-dollar" basis according to a specific fee schedule.

Facility Charges — charges from an eligible medical institution such as a hospital, residential treatment center, detoxification center, ambulatory or separate surgical center, dialysis center, or a skilled nursing center. These charges are generally paid under the basic benefits (hospitalization) portion of the Traditional Plan.

Family or Medical Leave of Absence — a period of time of pre-determined length, approved by the employer, during which the employee does not work, but after which the employee is expected to return to active service. Any employee who has been granted an approved leave of absence in accordance with the Family and Medical Leave Act of 1993 shall be considered to be active for purposes of eligibility for covered services and supplies under your group's program.

First-Dollar Basis — a provision of a benefit plan that provides reimbursement for incurred health care costs "from the first eligible dollar" with no deductible.

Full Medicare Coverage — enrollment in both Part A (Hospital Insurance) and Part B (Medical Insurance) of the federal Medicare Program. ***State law requires that anyone who is enrolled in the Retired Group and is eligible for Medicare must enroll in both Parts A and B of the Medicare Program in order to be covered in the State Health Benefits Program.***

Government Hospital — a hospital which is operated by a government or any of its subdivisions or agencies. This includes any federal, military, state, county or city Hospital.

Home Health Agency — a provider which mainly provides skilled nursing care and therapeutic services for an ill or injured person in the home under a home health care program designed to eliminate hospital stays. To be eligible for reimbursement it must be licensed by the state in which it operates, or be certified to participate in Medicare as a home health care agency.

Hospice — a provider that renders a health care program which provides an integrated set of services designed to provide comfort, pain relief and supportive care for terminally ill or terminally injured people under a hospice care program.

Hospital — an approved institution that meets the tests of (1), (2), (3), (4), or (5) below:

(1) It is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals and Medicare approved.

(2) It (a) is legally operated, (b) is supervised by a staff of doctors, (c) has 24-hour-a-day nursing service by registered graduate nurses, and (d) mainly provides general inpatient medical care and treatment of sick and injured persons by the use of the medical, diagnostic, and major surgical facilities in it.

(3) It is licensed as an ambulatory or separate surgical center. The center must mainly provide outpatient surgical care and treatment.

(4) It is an institution for the treatment of alcoholism not meeting all the tests of (1) or (2) but which is:

- *A licensed hospital; or*
- *A licensed detoxification facility; or*
- *A residential treatment facility which is approved by a state under a program that meets standards of care equivalent to those of the Joint Commission on Accreditation of Hospitals.*

(5) It is a birth center that is licensed, certified, or approved by a department of health or other regulatory authority in the state where it operates or meets **all** of the following tests:

- It is equipped and operated mainly to provide an alternative method of childbirth.
- It is under the direction of a doctor.
- It allows only doctors to perform surgery.
- It requires an exam by an obstetrician at least once before delivery.
- It offers prenatal and postpartum care.
- It has at least two birthing rooms.
- It has the necessary equipment and trained people to handle foreseeable emergencies. The equipment must include a fetal monitor, incubator, and resuscitator.
- It has the services of registered graduate nurses.
- It does not allow patients to stay more than 24 hours.
- It has written agreements with one or more hospitals in the area that meet the tests in (1) or (2) above and will immediately accept patients who develop complications or require post-delivery confinement.
- It provides for periodic review by an outside agency.
- It maintains proper medical records for each patient.

Hospital — does not include a nursing home. Neither does it include an institution, or part of one, that:

- Is used mainly as a place for convalescence, rest, nursing care, or for the aged or drug addicts.
- Is used mainly as a center for the treatment and education of children with mental disorders or learning disabilities.
- Provides homelike or custodial care.

Hospitalization Benefits — benefits provided under a policy for hospital charges incurred by an insured person because of an illness or injury. Also known as **basic benefits**.

Illness — any disorder of the body or mind of a covered person.

Indemnity Plan — a plan that allows members to choose any eligible provider and hospital for service and then receive specific cash payment reimbursement for designated covered services. Payments can be made either to enrollees or directly to health providers. This type of plan is also referred to as fee-for-service. The Traditional Plan is an indemnity plan.

Indication — a use; a circumstance (may be symptom or symptoms).

Injury — damage to the body of a covered person.

Local Employee — For purposes of SHBP coverage, a local employee is a full-time employee receiving a salary and working for a Participating Local Employer. Full-time shall mean employment of an eligible employee who appears on a regular payroll and who receives salary or wages for an average number of hours specified by the employer, but not to be less than 20 hours per week. It also means employment in all 12 months of the year except in the case of those employees engaged in activities where the normal work schedule is 10 months. In addition, for local coverage, employee shall also mean an appointed or elected officer of the local employer, including an employee who is compensated on a fee basis as a convenient method of payment of wages or salary but who is not a self-employed independent contractor compensated in a like manner. To qualify for coverage as an appointed officer, a person must be appointed to an office specifically established by law, ordinance, resolution, or such other official action required by law for establishment of a public office by an appointing authority. A person appointed under a general authorization, such as to appoint officers or to appoint such other officers or similar language is not eligible to participate in the program as an appointed officer. An officer appointed under a general authorization must qualify for participation as a full-time employee.

Local Employer — government employers in New Jersey, including counties, municipalities, townships, school districts, community colleges, and various public agencies or organizations.

Maintenance Care — sometimes treatment for a medical condition reaches a plateau and further treatment cannot reasonably be expected to improve your condition. This often happens in conditions treated by chiropractic manipulation or physical therapy. Maintenance care is considered to be not medically needed and thus is ineligible for benefit under the plan.

Major Medical Benefits — the supplemental program for health insurance that provides a reimbursement of eligible expenses beyond the basic benefits. The program normally provides for a deductible and coinsurance formula for specific services (generally involving major illnesses and injuries). Full reimbursement is often provided once the expenses paid by the individual reach a certain level. Although the maximums that limit total benefits are usually substantial, maximums are generally specified and mean that most policies do not provide completely unlimited protection. Limits on particular services, such as psychiatric care, may also be specified.

Medically Necessary and Appropriate — A service or supply that Horizon BCBSNJ determines meets **each** of these requirements:

- It is ordered by a doctor for the diagnosis or the treatment of an illness or injury.
- The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's

medical condition.

- It is furnished by an eligible provider with appropriate training, experience, staff, and facilities to furnish this particular service or supply.

Horizon BCBSNJ will determine whether the above requirements have been met based on the following:

- Published peer-reviewed reports in authoritative medical literature.
- Regulations, reports, publications, or evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and Food and Drug Administration (FDA).
- Listings in the following drug compendia: The *American Medical Association Drug Evaluations*. The *American Hospital Formulary Service Drug Information*, and the *United States Pharmacopoeia Dispensing Information*.
- Other authoritative medical sources to the extent that Horizon BCBSNJ determines them to be necessary.

Medical-Surgical or Professional Benefits — basic benefits under the Traditional Plan for professional charges such as X-rays and lab tests and surgical expenses toward the doctor's operating fees. Medical-surgical benefits are paid on a set fee schedule and remaining eligible charges are then automatically considered under the major medical portion of the plan. Also known as **extended basic benefits**.

Medicare — the federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medical coverage consists of two parts: Part A is Hospital Insurance Benefits and Part B is Medical Insurance Benefits. A Retired Group member and/or spouse who are eligible for Medicare coverage by reason of age or disability must be enrolled in Parts A and B to enroll or remain in SHBP Retired Group coverage.

Member — an employee, retiree or dependent who is enrolled under the Traditional Plan.

Member Hospital — a health care facility licensed by the State it is in to provide hospital care and services or any U.S. Government-operated hospital which has an agreement with Blue Cross and Blue Shield to provide hospital care both to a) the Blue Cross plan's subscribers and b) other Blue Cross plans' subscribers through the Blue Card Program.

Mental or Nervous Condition — a condition which manifests symptoms which are primarily mental or nervous, whether organic or non-organic, biological or non-biological, chemical or non-chemical in origin and regardless of cause, basis or inducement, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication. Mental or nervous conditions include, but are not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. Mental or nervous condition does not include substance abuse or alcoholism.

Mouth Condition — a condition involving one or more teeth, the tissue or structure around them, or the alveolar process of the gums.

Off-Label Use — a drug not approved by the FDA for treatment of the condition in question or prescribed at a different dosage than the approved dosage.

Participating Provider — a doctor or hospital which has a written agreement with their local Blue Cross and Blue Shield plan to provide care to both that plan's members and other Blue Cross and Blue Shield plan members.

Primary Health Plan — a plan which pays benefits for a member's covered charge first, ignoring what the member's secondary plan pays. A secondary health plan then pays the remaining unpaid allowable expenses in accordance with the provisions of the member's secondary health plan.

Provider — Under the SHBP, the term is used to define an eligible provider and includes medical doctors, dentists, podiatrists, acupuncturists, psychologists, psychiatrists, nurse midwives, licensed clinical social workers, chiropractors, certified nurse practitioners, clinical nurse specialists, physical therapists, occupational therapists, optometrists, and audiometrists who are properly licensed and are working within the scope of their practice.

Reasonable and Customary — The plan makes payments based on the reasonable and customary (R&C) fee for supplies and services in a specific geographic area. The R&C fee is the general level of charges made by others in the area for like services or supplies as determined by the Prevailing Healthcare Charges System (PHCS). This schedule is updated on a semi-annual basis. R&C fees are based on actual charges by physicians in a specific geographical area for specific services.

Residential Treatment Facility — a health care facility licensed, certified, or approved by the State of New Jersey for treatment of alcoholism or substance abuse or meeting the same standards, if out-of-state.

Retired Group Member — an eligible retiree of a state-administered or local public pension fund who has met the requirements for participation and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him- or herself and, if applicable, any eligible dependents. Also includes a surviving spouse of a deceased Retired Group member who has met the requirements for and has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP for him- or herself and, if applicable, any eligible dependents. Also includes a surviving dependent child of a deceased Retired Group member who had parent-child(ren) coverage, providing (s)he has completed a form constituting written notice of election to enroll for coverage in the Retired Group of the SHBP.

SHBP Member — an individual who is either a SHBP Active Group, Retired Group, or COBRA participant.

Skilled Nursing Facility — a facility which is approved by either the Joint Commission on Accreditation of Health Care Organizations or the Secretary of Health and

Human Services and provides skilled nursing care and services to eligible persons. The skilled nursing facility provides a specific type of treatment that falls midway between a hospital that provides care for acute illness and a nursing home that primarily provides assistance with daily living.

State Biweekly Employee — for purposes of SHBP coverage, state biweekly employee shall mean a full-time employee of the State, or an appointed or elected officer, paid by the State's centralized payroll system whose benefits are based on a biweekly cycle. Full-time normally requires 35 hours per week.

State Monthly Employee — for purposes of SHBP coverage, state monthly employee shall mean a full-time employee of the State, or an appointed or elected officer, whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). Full-time shall mean the usual full-time weekly schedule for the particular title, which normally requires 35 hours per week.

State Monthly Employer — employers whose benefits are based on a monthly cycle and whose payroll system is autonomous (not paid by the State's centralized payroll system). This includes state colleges and universities and participating independent state commissions, authorities, and agencies such as:

- Rutgers, the State University of New Jersey
- Palisades Interstate Park Commission
- New Jersey Institute of Technology
- University of Medicine & Dentistry of NJ
- Thomas A. Edison State College
- William Paterson University
- Ramapo State College
- Rowan University
- College of New Jersey
- Montclair State University
- New Jersey City University
- Kean University
- Stockton State College
- State legislature and legislative offices
- Agencies or special projects that are supported from, or whose employees are paid from, sources of revenue other than general funds, which other funds shall bear the cost of benefits under this program.

Substance Abuse — the abuse or addiction to drugs or controlled substances, not including alcohol.

Supportive Care — Frequently, treatment for a chronic condition, such as a bad back, reaches a plateau. That is treatment brings a member to a point when further treatment cannot be reasonably expected to improve the diagnosed condition. Instead it main-

tains the members' current condition. When such a point is reached, further treatment is deemed to be supportive or maintenance care and is no longer eligible for coverage.

Surgical Center — also termed as surgicenter. An ambulatory-care facility licensed by a state to provide same-day surgical services.

Surgical Procedure — this includes cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, application of plaster casts, electrocauterization, tapping (paracentesis), administration of pneumothorax, endoscopy, or injection of sclerosing solution.

Waiting Period — the period of time between enrollment in the program and the date when you become eligible for benefits.

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